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ABSTRACT

The general status of Ohio's school program of speech and hearing therapy is described in terms of its historical perspective and past achievements, the present status of therapist employment, percentages of trained personnel provided by various universities, and suggestions for needed research. Information concerning program standards includes the areas of certification, state board of education program standards and related division policies, equipment and facilities, program organization, records and reports, sources of professional assistance, and an overview of the program within the school system. The hearing conservation program is summarized, and methods of audiometric evaluations are provided. (RD)

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OHIO SCHOOL SPEECH AND HEARING THERAPY

EC 005 209E

STATE BOARD OF EDUCATION
OHIO

State Department of Education
Columbus, Ohio

1969

U.S. DEPARTMENT OF HEALTH, EDUCATION & WELFARE
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OHIO SCHOOL SPEECH AND HEARING THERAPY

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FOREWORD

OHIO SCHOOL SPEECH AND HEARING THERAPY is designed to assist administrators and therapists in developing and maintaining effective programs in the remediation of communication disorders among school children. The focus of the publication is to define and clarify speech and hearing therapy, as outlined in program standards adopted by the State Board of Education, and to give useful information to school districts who wish to develop services to the estimated five to eight percent of school aged children who have disabilities in communication.

Effective communication is of major importance in our increasingly complex society, and school systems have come to recognize a responsibility to habilitate children whose communication skills impede educational, occupational, and emotional growth and development. Since 1945, the Ohio Department of Education has offered consultive, informational and monetary support to local school districts for programs for speech, hearing and language impaired children. The speech and hearing therapists who serve the schools of Ohio provide the best available specialist to help such handicapped children solve or adjust to their difficulties.

OHIO SCHOOL SPEECH AND HEARING THERAPY has been designed to offer assistance to school personnel who wish to commence or implement a program of speech and hearing therapy services for handicapped children. It is hoped that this publication will be useful to all personnel concerned with speech and hearing handicapped children.

S. J. Bonham, Jr., Director
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INTRODUCTION

As evidenced by legislative support and the development of comprehensive educational programs in the public schools, the citizens of Ohio have demonstrated their belief in the right of each student to equal educational opportunities. Since 1945 when the first comprehensive permissive legislation for education of handicapped children was enacted (Section 3323.01 Ohio Revised Code), schools in Ohio have systematically been providing services for students with speech and hearing disabilities in increasing numbers until by the 1967-68 school year 566 therapists were served 56,794 children with communicative handicaps.

The Division of Special Education of the Ohio Department of Education has the responsibility for encouraging the establishment and maintenance of special services for speech and hearing impaired children in local school districts. The State Board of Education establishes minimum standards for programs for speech and hearing handicapped children, and school districts wishing to receive state funds under the provisions of the School Foundation Program for speech and hearing therapy services must meet these standards (Section 3323.02 Ohio Revised Code).

Since provisions were made in 1945 for the position of a state consultant in this area, the Ohio Department of Education has consistently attempted to insure that habilitative services are made available to speech and hearing impaired children. An important role of the State Department of Education is to prepare information for dissemination which will assist professional personnel in developing effective programs for handicapped children in local school districts. This publication, a compilation of the work of many professionals in speech and hearing therapy, is such an attempt.

The Advisory Committee, listed on page four was of considerable help in preparing, outlining, and recommending content for this publication. Without their assistance, the task of compiling OHIO SCHOOL SPEECH AND HEARING THERAPY would not have been possible. Their critical contributions gave much needed depth and breadth to the publication. The support, encouragement, and leadership of Mr. S. J. Bonham, Jr., Director, Division of Special Education, was important to this endeavor. Finally, to Mrs. Alma Angel, sincere thanks for efficiency and patience in preparing the manuscript for publication.

It is hoped that this publication will be useful to all personnel involved in providing speech and hearing services to the school children of Ohio.

F. P. Gross
Educational Adminstrator
Pupil Services

PART I

GENERAL STATUS OF OHIO'S PROGRAM

Chapter 1

HISTORY OF SPEECH AND HEARING THERAPY IN OHIO

General History

School speech and hearing therapy services in Ohio have been gradually developing since before World War I. There has been a continuous program of speech correction in the Cincinnati City Schools since 1912, while the Cleveland Schools commenced its program in 1918. Akron City Schools started in 1935, Dayton began in 1944, and Youngstown in 1945. Interest was slow to develop, and by 1945 only seven speech and hearing therapists were employed by public schools, four of them in Cleveland. In the early 1940's, students expressing interest in school speech and hearing therapy were often discouraged by universities because of the lack of positions available in the schools.

Instruction in speech correction at the university level began at Ohio State University in 1931. Western Reserve (now Case-Western Reserve), Kent State, and Ohio Universities initiated programs about 1937, and Bowling Green State University commenced in 1944. By 1945, it is estimated that there were between five and six full-time university instructors in speech correction in Ohio. Akron (1957) and Miami University (1954) and the University of Cincinnati also developed approved programs in school speech and hearing therapy, and several other universities offer one or more courses leading to state certification at the present time.

Ninteen hundred and forty-five was a critical year in the development of programs for handicapped children in Ohio's schools. Legislation was established which broadened the statutes so that special education services could be provided to a wide range of handicapped children, including those with speech defects or hearing losses (Section 3321.01 Ohio Revised Code). In the same year, the 96th General Assembly mandated that the State Board of Education establish standards for programs and services for handicapped children for the purposes of determining school districts entitled to state financial support. In addition, the State Board of Education was empowered to employ consultants to assist in the development and maintenance of state-wide programs for handicapped children, provide consultation to local school districts, and to determine that state subsidies were appropriately utilized (Section 3321.02 Ohio Revised Code). The first consultant in speech and hearing therapy was employed by the Ohio Department of Education in 1945. That same year provisions for state subsidies to school districts for providing speech and hearing therapy services was established at a level equal to $1,000 for each state-approved therapist who served more than one school.

Because of the favorable permissive legislation and state subsidies which were enacted in 1945, employment opportunities for speech and hearing therapists for the first time exceeded the supply. Demand has increased in each succeeding year until in 1968, 301 vacant positions were registered by school superintendents with the Division of Special Education.

Certification requirements were an important early problem which continues to date. Initial interpretation of certification requirements mandated that the speech and hearing therapist be qualified to teach both the hard of hearing and the speech handicapped child. This dual pattern did not appear practical for the developing role and function of Ohio's speech and hearing therapists, and a special committee was formulated to study the problem. In 1946, the State Board of Education adopted certification requirements for speech and hearing therapy which became effective January 1, 1948 and mandated the equivalent of 30 semester hours of training in speech and hearing areas in addition to fifteen semester hours in psychology and special education. Requirements have been continuously evaluated until at the present time 56 semester hours of academic course work is prescribed for minimal certification. (See Chapter 5)

Since 1945, both state funding and minimal state standards have also undergone continuous revisions in efforts to provide improved services which can be supported at reasonable fiscal levels. In 1955, the 101st General Assembly adopted a new foundation program for Ohio schools. This program established a classroom of

30 children as a basic unit. A minimum level of financial support was guaranteed by the foundation program. The employment of a school speech and hearing therapist under State Board of Education Program Standards (See Chapter 6) entitled the employing district to an additional unit in its calculations for state support. Support generally ranged from $2,100 to $7,622, depending upon the nature of the school district and training of the therapist. In the fall of 1967, the legislature of the State of Ohio improved subsidies for approved units in speech and hearing so that in general school districts now receive a minimum of $3,050 for an approved unit, up to a maximum of virtually complete subsidy.

The criteria upon which state subsidies for approved units are based may be found in Chapter 7. The State Board of Education Approved Program Standards are periodically revised to take account of new research data and changing school and professional needs. Changes are made after considerable consultation with professional organizations and advisory committees established for this purpose. In 1960, the State Board of Education adopted new standards for speech and hearing therapy services. These standards were further revised in 1962 and 1966.

TABLE I
Number of Therapists Employed 1946-47 Through 1959-60 School Years

Year	No. of Therapists	Year	No. of Therapists
1946-47	25	1953-54	119
1947-48	36	1954-55	122
1948-49	48	1955-56	141
1949-50	56*	1956-57	151
1950-51	68	1957-58	162
1951-52	94	1958-59	222
1952-53	104	1959-60	248

* Note: No report was tabulated for the 1949-50 school year because the position of state consultant was not filled, and the number of therapists was estimated.

Growth in Program

With the advent of permissive legislation and state financial support in 1945 the number of speech and hearing therapists employed by Ohio's school systems has grown consistently each year. The overall growth of the program is shown in the two tables that follow. The first table traces the number of therapists employed from the 1946-47 through the 1959-60 school years.

Commencing with the 1960-61 school year, data was tabulated in a different manner. In Table I above, the total number of speech and hearing therapists employed is included. The data reflects a number of part-time personnel. In Table II below, both the total number of therapists and full-time equivalents are indicated, as well as information relative to case loads and percentage of cases corrected.

TABLE II

Therapists Employed
1960-61 Through 1967-68 School Years

Year	No. of Units	Total Therapists	Enrollment	Mean Case Load	Percent Corrected
1961-62	292.9	303	35,636	121	37%
1962-63	305.6	315	36,391	119	36%
1963-64	347.4	365	39,171	113	37%
1964-65	404.8	428	47,279	117	46%
1965-66	449.8	473	51,424	114	46%
1966-67	472.6	504	53,764	114	37%
1967-68	526.6	566	56,794	100	37%*

It would appear that in the last two decades school speech and hearing therapy has become a well-established profession within the schools of Ohio. Services are being demanded in ever increasing numbers. However, it would appear that even more help is needed by speech, hearing and language handicapped children. If one accepts the premise that at least six percent of school-age children need rehabilitation in speech, hearing, and language, approximately 141,000 of the 2,357,000 children presently enrolled in Ohio's public schools need special services. Less than one-half of the children needing a speech and hearing therapist are receiving assistance.

Chapter 2

PRESENT STATUS OF UNITS IN SPEECH AND HEARING

General

Since 1945, the Division of Special Education of the Ohio Department of Education has offered assistance to schools throughout the state in developing statistical data regarding the nature, duties, functions, and basic issues in speech and hearing therapy which can be utilized in planning and implementing programs by local educational agencies, professional organizations, and university trainers.

In an effort to develop the information included in this chapter relative to the present status of units in school speech and hearing therapy services, staff members of the Division of Special Education, in cooperation with the Ohio Speech and Hearing Association and the Ohio Inter-University Council of Trainers of Speech and Hearing Therapists, developed a questionnaire which was distributed in May, 1966 to all public school speech and hearing therapists. Ninety and four-tenths percent of Ohio's therapists responded to one or more items on the questionnaire. Selected portions of the responses are discussed in this chapter.

School District Data

Table I indicates the number of full and part-time therapists employed by school districts of varying sizes. Therapists tend to work either in very large city districts, or in moderately sized suburbs with a school population of between 3,000 and 8,000.

Fifty-one of the 88 Ohio counties have therapy services either in the county office or in local school districts within the county. The majority of the 37 remaining county areas have for several years been trying to secure therapy services.

It is of interest to note that of the 301 vacant positions registered by superintendents with the Division of Special Education in 1968, a great number were listed from these areas. It would appear that speech and hearing therapists have tended to seek employment in major cities or their suburbs rather than the rural areas of the state, even though there are many positions available in these locations.

TABLE I
Size of School District

Size	Full-Time Therapist	Part-Time Therapist	Total Therapist	Percentage	Cumulative Percentage
Below 3,000	70	17	90	20.6	20.6
3,000 to 7,999	109	13	122	27.9	48.5
8,000 to 12,000	54	2	56	12.8	61.3
13,000 to 17,999	27	3	30	6.8	68.1
18,000 to 50,000	35	3	38	8.9	77.0
Over 50,000	96	5	101	23.0	100.0
	N = 394	43	437		

Coordination Time

According to Program Standards for Special Education Units for Speech and Hearing Therapy, not less than one-half nor more than one day per week should be allocated for coordination of the program, parent, staff, and agency conferences concerning individual students, and related follow-up activities.

Table I below outlines activities done during the one-half to one full day designated in the therapist's schedule as coordination time. "Regular" activities were those accomplished as a routine or regular responsibility. Activities noted as "seldom" done were those accomplished less than three times a year. Due to the nature and design of the questionnaire, many therapists found it expedient to list additional activities. Among the most commonly cited and pertinent were: (1) therapy with children not regularly enrolled in class, in special education classes, and make-up sessions for children on the regular caseload; (2) random diagnostic evaluations to assist in referring children for pre-school services and in schools without therapy services; (3) observation of the child in the classroom situation; (4) visitations to children's homes, schools for hearing handicapped, and specific medical facilities; (5) inservice training programs for new therapists, student therapists, and high school classes; (6) preparation of lessons and materials for therapy sessions; and (7) evaluation and diagnostic work with new referrals.

TABLE I
Activities During Coordination Time

Area	Total	Regular	Percentage	Seldom	Percentage
Hearing Testing	431	289	67	142	33
Parent Conferences	434	382	88	52	12
Teacher Conferences	428	339	79	89	21
Writing Reports	418	331	79	87	21
Scheduled Therapy	404	213	52	191	48
Research	367	64	18	303	82
Administrative Staff Meetings	389	162	49	227	59
Visitations to outside agencies	390	64	14	326	86

Responsibilities during coordination time vary considerably according to the background and training of the therapist and the basic philosophy of the school district involved. It is important to emphasize that school speech and hearing therapists, as professional personnel, should utilize coordination time to work in depth on those important adjuncts to direct speech and hearing therapy which are just as essential to the habilitation of the child on the case load, such as conferences with doctors, otologists, social workers, administrators, and the like. It should also be clear that a speech and hearing therapist is a professional staff member who should expect to devote additional time beyond coordination time and the normal school day in preparing lessons, record keeping, and holding or attending professional conferences.

Private Practice

Approximately one therapist in five engages in private practice beyond his normal school employ, as the following table indicates:

With the critical shortage of speech and hearing therapists in many areas of the state, opportunities for private practice are increasing. Most educational associations indicate that it is not

TABLE I
Number of Hours Per Week Spent in Private Practice

No. of Hours	No. Therapists	Percentage	Cumulative Percentage
None	350	80.0	80.0
1 - 3	64	14.7	94.7
4 - 6	12	2.8	97.5
7 - 9	5	1.1	98.6
10 - 12	5	1.1	99.7
13 - 15	0	0.0	99.7
17 - 19	1	0.3	100.0

N = 437

ethical for a professional school employee to provide service for fee for any individual who would be entitled to that service under ordinary circumstances. It would be considered unethical, for example, to provide for a fee any service as a speech and hearing therapist to a child attending school in one's own district of employment.

Contract and Remuneration

Salaries for speech and hearing therapists in general reflect the "law of supply and demand." Especially in school districts outside of the eight major metropolitan areas of Ohio, differentials above the regular teachers' salary schedule are often given if it is difficult to recruit this kind of special service. During the 1965-66 school year, thirty-two percent of Ohio's therapists received differentials which ranged from $100 to $1200. The remainder were on the regular teachers' salary schedule of the local school district. The Table below indicates salaries for school speech and hearing therapists for the 1965-66 school year:

TABLE II
Percentile Rank of Salaries

Percentile	Salary
99	$9,719
95	8,700
90	7,516
75	6,380
50	5,700
25	5,300
10	5,200
5	5,041
1	4,900

Of the total of 410 therapists reporting, fifty-nine percent were in the $5,000 to $6,000 range. Only two therapists reported salaries above $10,000. Twenty-seven percent of therapists are employed longer than nine and one-half months, with employment either in non-school public or private agencies or on extended service in their employing school district (7.6% of therapists). Most extended service is in the major city school districts. One speech therapist in twelve is reimbursed for additional responsibility, usually of a supervisory nature.

Except in areas where a therapist is only assigned to one or two buildings for services, it is a general practice for school districts to provide a travel allowance to compensate for commuting between schools. Eighty-one and two tenths percent of therapists receive some compensation for travel expenses, as the following table suggests:

TABLE V
Travel Allowance

Category	No. Therapists	Percentage
None	81	18.8
Flat Rate Per Year	101	23.3
$ 50 - 99	18	
100 - 149	36	
150 - 199	10	
200 - 249	20	
Over 250	25	
Flat Rate Per Month	28	6.5
$ 1 - 10	7	
11 - 20	6	
21 - 30	4	
31 - 40	0	
41 - 50	11	
Mileage	222	51.4
Cents Per Mile		
6	2	
7	8	
8	70	
9	62	
10	37	
11	43	

N=432

Experience

One of the critical problems in school speech and hearing therapy is the rapid turnover encountered throughout the state. In 1967, twenty-three percent of therapists were in the first year of employment, while seventy-six percent had five or fewer years of experience. On a state-wide basis, there is an annual turnover of between thirty-five and forty percent.

In addition, the percentage of women making school speech and hearing a profession has been increasing. In 1954, twenty-four percent of speech and hearing therapists were male, while during the 1967-68 school year only one in ten was male. The rapid turnover, especially in small districts with few therapists, has created considerable difficulty to many school superintendents in providing continuity of services.

Chapter 3

TRAINING

Although records are somewhat incomplete for specific years, it would appear that despite the considerable impetus by the American Speech and Hearing Association, trainers, and others interested in increasing the educational background of speech and hearing therapists, the level of training as measured by degree status has not reflected this concern. During the 1953-54 school year, thirty-nine percent held the master's degree or beyond; this had decreased to twenty-five percent by 1959-60; to twenty-one percent in 1961-62; and to a fairly consistent twenty percent in each of the succeeding years.

The general youth of the profession as well as the difficulty in continuing graduate work in many areas of the state has resulted

TABLE I
University Conferring Undergraduate Degree

University	No. Therapists	Percentage
Ohio	84	20.2
Bowling Green State	83	20.0
Ohio State	64	15.4
Kent State	54	13.0
Miami	33	7.9
Case-Western Reserve	23	5.5
Akron	9	2.2
Cincinnati	6	1.4
Others	60	14.4

N = 416

TABLE II
University Conferring Graduate Degree

University	No. Therapists	Percentage
Kent State	19	23.75
Case-Western Reserve	17	21.25
Ohio State	11	13.75
Bowling Green State	8	10.00
Ohio	5	6.25
Miami	3	3.75
Akron	1	1.25
Cincinnati	0	0.00
Others	16	20.00

N= 80

in the fact that almost three of every four therapists are certificated by the Ohio Department of Education at the provisional level. Nine percent have temporary certification, while eleven percent hold the eight year professional and four percent the permanent levels in 1967-68. Chapter 5 shows the present certification requirements in each of these areas.

Ohio has eight training universities approved by the Ohio Department of Education for the purposes of training school speech and hearing therapists. Eighty-five and six tenths percent of Ohio's school speech and hearing therapists are trained by one of these approved universities. The supply of therapists from other states is not considered to be great.

The table below indicates the number of therapists who were employed by Ohio schools during the 1965-66 school year and were trained by each approved university:

Graduate programs have been developing fairly rapidly in Ohio, and increasing numbers of students are continuing their education beyond the minimum necessary for certification. Table II shows the institutions which prepared school speech and hearing therapists during the 1965-66 school year at the master's degree level.

Since 1931 when Ohio State University began its program, seven other training institutions have prepared school speech and hearing therapists. Of the institutions who do prepare school speech and hearing therapists in significant numbers at either the graduate or undergraduate level, most are located in the northern part of the state, or obtain a high proportion of their students from this metropolitan area. This has resulted in a surplus of therapists in much of this area of Ohio along with a shortage in other areas of the state. It has also made additional graduate training difficult to secure for therapists residing elsewhere.

Chapter 4

SUGGESTIONS FOR NEEDED RESEARCH

All areas of special education receiving state reimbursement, including public school speech and hearing therapy, operate within program standards adopted by the State Board of Education. In 1962, the State Department of Education adopted a provision to permit the development of research and demonstration programs. In Speech and hearing, this standard states that "a special education unit. . . . may be approved for experimental, demonstration, or research purposes designed to provide a new or different approach to the techniques and/or methodology related to speech and hearing therapy." These programs must have the prior approval of the Division of Special Education, and a report of the results of the experimental program must also be submitted. The Division of Special Education encourages school districts to submit ideas for research and demonstration programs for consideration, and it will work actively with local districts in implementing proposals.

Results of research and demonstration programs completed by local school districts in cooperation with the Division of Special Education have had a very significant impact on subsequent revisions of program standards. For example, pilot programs in Brecksville, Cleveland, Crawford County, Dayton, and East Cleveland which explored alternate methods of scheduling speech and hearing classes resulted in establishing the "intensive cycle" method of scheduling as an optional alternative to the traditional scheduling method. It was found that with intensive cycle scheduling more children could be programmed and consequently more could be dismissed from therapy as having reached maximum improvement, and that the method was especially effective with children having articulatory disorders. Primary disadvantages were that space monopolization difficulties occurred, and that some psychogenic problems were less effectively handled. In supervision of speech and hearing therapists and in the area of audiology, the Stark County Schools has been developing effective guidelines for a number of years.

A great deal of additional experimentation is needed. Changes in program standards should come only as a result of successful and documented research and demonstration programs, and can only come after new methods are attempted in local school districts.

With the tremendous change in all areas of education, especially as a result of Sputnik and subsequent increases of local, state, and federal funding (as the National Defense Education Act and the Elementary and Secondary Education Act), it is imperative that speech and hearing therapists be aware of the changes and be prepared to also change and improve as a profession. With the provision in State Board of Education Standards for experimentation, and with the eagerness of the Division of Special Education to cooperate with local districts in improving the effectiveness of school speech and hearing therapists, any school system having creative ideas should begin to plan to develop research and demonstration programs.

Some of the critical areas of concern in Ohio school speech and hearing therapy which need to be evaluated and "field tested" are:

1. What is the best size of case load by age, type of problem, or age of child?
2. Are there new, different, and innovative techniques in the process of speech therapy itself?
3. What is the role of a qualified audiologist in a special education program? How is his role and function similar to and different from other special education personnel?
4. Since only 1,034 children or 1.8 percent of the typical therapists' case load, were in the area of hearing impaired, how can hearing handicapped be more effectively treated?
5. With a continuing shortage of qualified speech and hearing therapists, especially in certain areas of the state, should a speech and hearing therapist aide be considered? If so, how can he best be trained, and what can he do best? What is the supervisory role of a speech and hearing therapist?
6. With more than ninety percent or more of the children in some inner city schools exhibiting problems in the speech improvement area, how can this problem most effectively be approached?
7. How can a program of in-service education be efficiently developed, especially for therapists working independently in a school district?
8. What is the therapist's role in the first few grades where many minor articulation problems improve by maturation? How can the therapist successfully identify these

children so that she can work most effectively with the more serious cases?

9. What diagnostic instruments need to be developed to aid therapists? Can therapists in local districts, given some released time and technical assistance, improve on present instruments?
10. What are realistic incidence figures for speech and hearing problems in varying types of districts? What is a reasonable case load to expect? Does this figure vary by type of district? What different approaches are needed for the wealthy suburb as opposed to the inner-city area?
11. What happens to a student after he is dismissed from therapy? Of the 56,794 children receiving service during the 1967-68 school year, thirty seven percent were reported corrected or dismissed due to having obtained maximum improvement. What criteria is used for dismissal? How many do not remain corrected, and why? Since Ohio's dismissal figure is somewhat higher than some other states', are Ohio therapists dealing primarily with minor articulation problems, or is there some other reason with broad implications for training and role and function?
12. Why is only ten percent of a therapist's case load composed of children in the upper six grades? If this because it is more difficult to schedule services, that there are fewer cases, or that the therapist feels uncomfortable with the types of problems older children exhibit? Are problems at this age level of a more severe nature that fewer must be scheduled for efficient treatment?

Other more serious concerns face Ohio's school speech and hearing therapists which cannot easily be field tested, but need to be objectively considered since the effect on daily therapy sessions is significant, if only indirectly. For example:

1. Seventy-six percent of Ohio's therapists have five or less years of experience. In 1966-67, 176 of 473 Ohio school speech and hearing therapists had not been employed as therapists the preceding year. Annual turnover is between thirty-five and forty per cent. This constant turnover and inexperience in the profession has caused serious problems in some areas, especially in terms of continuity of therapy services and continuing in-service education. How can these problems be overcome?

2. Ninety percent of Ohio's therapists are women, about ten percent higher than nationally. Why are there so few men in Ohio willing to consider speech and hearing therapy as a profession?
3. Seventy-nine and nine tenths of Ohio's school speech and hearing therapists are at the bachelors' degree level, and many therapists seem to be unwilling or unable to further their education due to family or geographical reasons. This is also reflected in the fact that only 18.6 per cent of the (94 of 504) Ohio therapists in 1966-67 had certification about the provisional level. What implications does this have for the profession?
4. Geographical distribution of therapists is a problem, since therapists tend to be employed in major cities and their suburbs and close to one of the eight training institutions. One major city employes twice as many speech therapists as the total employed in all twenty-eight Appalachian area counties. This unequal distribution needs to be solved somehow.

The State of Ohio has recognized officially and by statutes for over two decades the importance of special services to school children such as speech and hearing therapy. In addition, the State of Ohio has, through the School Foundation Program, funded to a significant degree, the expenses of local school district associated with the employment of therapists. In order to insure minimal services to speech and hearing handicapped children, the State Board of Education has been authorized to adopt certification standards and to establish program standards within which speech and hearing therapy programs must operate.

The Ohio Department of Education has recognized that it must encourage research and demonstration in the schools to ascertain how to solve some problems in the area and how to improve services to handicapped children. For this reason, research and demonstration programs have been actively encouraged, and the results of these experimental programs have been incorporated in program standards by the State Board of Education wherever feasible. We are presently living in a rapidly changing world, especially in education. Speech and hearing therapy as a profession must be cognizant of the fact that it is also changing. Provisions are available for school districts to experiment with ways to improve therapy services, and suggestions have been given of a few areas where such research is needed in Ohio.

PART II

CERTIFICATION AND PROGRAM STANDARDS

Chapter 5

CERTIFICATION

General

Every speech and hearing therapist who wishes employment in the schools of Ohio should plan to apply for proper certification. Ohio law states that "no person shall receive any compensation for the performance of duties as a teacher in any school supported wholly or in part by the State or by federal funds who has not obtained a certificate of qualification for the position (Section 3319.30 Ohio Revised Code).

The issuance of certificates for all public school professional personnel in Ohio is the responsibility of the Division of Teacher Education and Certification, Room 605, Ohio Departments Building, Columbus, Ohio 43215. Questions not resolved at a local level relative to certification may be addressed to this office.

Grade of Certificates

A. *The Provisional Certificate* may be issued "to those who have completed the respective courses prescribed" by the State Board of Education in an "institution approved by it" for the preparation of school speech and hearing therapists. There are eight approved Ohio institutions: Akron University, Bowling Green State University, Case-Western Reserve University, University of Cincinnati, Kent State University, Miami University, Ohio State University, and Ohio University. Application forms are processed by the institution where the student has completed his training. The provisional certificate is valid for four years, and may be renewed.

B. *The Professional Certificate* is valid for eight years. In order to qualify, a speech and hearing therapist must have completed 24 months of successful teaching experience in

Ohio under the provisional certificate. Eighteen semester hours of additional training are also needed. Application forms may be obtained from any school superintendent.

C. *The Permanent Certificate* is valid for life to those therapists who are employed in the schools of Ohio and have completed forty months of successful experience under the professional certificate. Application forms may be obtained from any school superintendent.

Out-of-State Credentials

Speech and hearing therapists whose preparation has been in the schools of another state may be certificated in Ohio provided that:

A. The pattern of training is substantially equivalent to the Ohio requirements.

B. The applicant holds a valid certificate in speech and hearing therapy from the state in which the training was completed.

C. The institution in which the training was completed is currently approved for teacher education by its own state department of education.

Professional Qualifications

The regulations for certification prescribed by the State Board of Education are minimal and should not be considered to be optimal. They are designed to provide adequate professional preparation, a breadth of general education, and an adequate basic preparation in school speech and hearing therapy. Each of the eight approved Ohio training institutions require additional preparation beyond state minimal certification requirements.

A. Courses in Education . . . . 17 semester hours
Courses shall be distributed over the following areas with at least one course in each area:

1. Educational Psychology
2. Principles of Teaching (or Education)
3. Elementary and secondary classroom organization and management (emphasizing curriculum, procedures and materials)
4. Educational Methods
   Organization and administration of a public school speech and hearing therapy program

5. Student teaching and supervised field work in speech correction and lipreading (minimum of 100 clock hours in public schools)

B. Courses in Psychology .... 15 semester hours

Courses shall be distributed over the following areas with at least one course in each area:

1. Personal Adjustment or Mental Hygiene
2. Psychology or Education of the Exceptional Child
3. Child Growth and Development or Child Psychology
4. Adolescent Psychology
5. Psychology Tests and Measurements
6. Psychology of Speech (emphasis on stuttering)

C. Courses in Speech and Hearing ..... 24 semester hours

Courses shall be distributed over the following areas with at least one course in each area:

1. Voice and Articulation
2. Phonetics
3. Beginning Speech Correction or Pathology
4. Advanced Speech Correction or Pathology
5. Introduction to Audiology (Audiometry)
6. Clinical practice in Speech Therapy
   (75 clock hours minimum)
7. Methods in Speechreading
8. Clinical practice in Speechreading
   (25 clock hours minimum)
9. Elective in Hearing

Chapter 6

STATE BOARD OF EDUCATION PROGRAM STANDARDS

The Division of Special Education of the Ohio Department of Education has the responsibility for encouraging functional and effective services for speech and hearing impaired children in Ohio's schools. According to law (Section 3323.02 Ohio Revised Code) first established in 1945, the State Board of Education establishes minimum standards for programs for such children, and school districts wishing to receive state funds under the provisions of the School Foundation Program must meet the standards.

The basic standards approved by the State Board of Education were approved in April, 1960 and were revised in July, 1962 and August, 1966 to take account of changes in the utilization of speech and hearing therapists. Most of the essential changes were a result of research and demonstration programs designed to explore new or different approaches to the techniques and/or methodology related to speech and hearing therapy.

These standards are felt to be minimal, and school districts are encouraged to go beyond them to develop the most effective program possible. Prior to adoption of the standards by the State Board of Education, a number of professional organizations and interested personnel offered considerable advice and suggestions which are incorporated throughout. These include:

1. The Ohio Speech and Hearing Association
2. Ohio Inter-University Council of Trainers of Speech and Hearing Therapists
3. Division of Special Education Advisory Committee on Speech and Hearing Therapy (see page 3)
4. Division of Special Education Advisory Committee (composed primarily of administrators in the areas of pupil services and special education)

These groups were of considerable assistance in developing the minimal program standards for special education units for speech and hearing therapy, and the standards which were recommended and subsequently adopted by the State Board of Education reflect considerable thought and effort on the part of many professional personnel. The program standards are felt to be a minimal base upon which to approve programs for state reimbursement within the provisions of the School Foundation Program.

Edb-215-08 Program Standards for Special Education Units for Speech and Hearing Therapy

A. General

(1) A special education unit or fractional unit may be approved for speech and hearing therapy only within these standards.

(2) A special education unit or fractional unit may be approved for experimental, demonstration or research purposes designed to provide a new or different approach to the techniques and/or methodology related to speech and hearing therapy.

(3) One special education unit in speech and hearing therapy may be approved for the first 2,000 children enrolled in grades K-12 in a school district.

(4) Additional special education units in speech and hearing therapy may be approved for each additional 2,500 children enrolled in a school district in grades K-12.

(5) School districts employing four or more speech and hearing therapists may designate one therapist as coordinator for technical assistance and professional guidance. The case load of such a therapist may be lowered on a pro-rated basis.

(6) The number of centers in which a speech therapist works should be determined by the enrollment of the building and needs of the children. Not more than four centers are recommended, and the maximum shall not exceed six at any given time for one therapist employed on a full-time basis. Therapists employed less than full time shall reduce the number of centers served proportionately.

(7) Two or more districts may arrange cooperatively for the employment of one speech and hearing therapist.

B. Selection of Children

(1) Selection of children for speech and hearing therapy shall be made by the therapist.

- (2) The bases for selection of new students for speech therapy shall include:
    - (a) Diagnostic speech evaluation, including observation of the speech structures.
    - (b) Audiometric evaluation prior to initiating therapy.
    - (c) General examination by school or family physician when indicated.
    - (d) Referral of children with voice problems to an otolaryngologist through the school or family physician when indicated.
    - (e) Psychological services when indicated.
- (3) The bases for selection of children for speechreading (lipreading) and auditory training shall be:
    - (a) Individual audiometric evaluation.
    - (b) Otological examination, with a copy of the report filed with the speech therapist.

C. General Organization

- (1) Class size shall be limited to a maximum of five students.
- (2) Class periods shall be a minimum of thirty minutes for children seen in groups. Individual lessons may be fifteen to thirty minutes in length.
- (3) Each therapist shall maintain adequate records of all students, including those screened, those presently a part of the case load, and those dismissed from therapy.
- (4) Children shall not be dismissed from therapy before optimum improvement has been reached.
- (5) Periodic assessment of children dismissed from therapy should be made over a two-year period.

D. Methods of Scheduling

(1) Traditional Method of Scheduling

- (a) Elementary children shall be enrolled for a minimum of two periods weekly until good speech patterns are consistently maintained. Children may be seen less frequently in the "tapering off" period.

(b) Children enrolled in high school classes may be scheduled once a week, although twice-weekly sessions may be desirable where scheduling permits.

(c) One full-time therapist shall serve a minimum of 75 to a maximum of 100 students in active therapy.

(2) Intensive Cycle Method of Scheduling

(a) The speech and hearing therapist shall schedule at least four one-half days of each week in each center. One-half day per week should be used to follow up cases in previous cycles where continued reinforcement is indicated.

(b) Each speech center shall be scheduled for a minimum of 2 to a maximum of 4 intensive cycles per year.

(c) The length of a scheduled intensive cycle shall be a minimum of 5 to a maximum of 10 consecutive weeks.

(d) The individual intensive cycles scheduled at a particular center shall not be consecutive, but shall alternate with time blocks in other centers.

(e) The first intensive cycle scheduled at each center should be longer to provide sufficient time for screening, selecting pupils and initiating the program.

(3) Combination of Scheduling Methods

(a) A combination of the intensive cycle and traditional methods may be scheduled by a therapist based on a plan submitted to the Division of Special Education.

E. Housing, Equipment and Materials

(1) A quiet, adequately lighted and ventilated room with an electrical outlet shall be provided in each center for the speech and hearing therapist.

(2) The space in each center shall have one table with five medium size chairs, one teacher's chair, one bulletin board, one permanent or portable chalkboard, and

one large mirror mounted so that the therapist and students may sit before it.

(3) School district shall make available one portable individual pure tone audiometer for the use of the speech and hearing therapist.
  (a) A speaker attachment should be included for use in auditory training units.
  (b) The audiometer should be calibrated annually. Calibration shall be completed at least once every three years. Calibration to International Standards Organization specifications is recommended.

(4) School districts shall make available one portable tape recorder for the use of each speech and hearing therapist.

(5) Each speech therapist shall have access to a locked file, a private office, a telephone and appropriate secretarial services.

F. Conference and Follow-Up

(1) Not less than one-half nor more than one day per week shall be allocated for coordination of the program, parent, staff and agency conferences concerning individual students, and related follow-up activities.

(2) Part of the coordination time may be devoted to the development of speech and language improvement programs on a consultative basis.

G. Qualifications for Speech and Hearing Therapists

(1) All speech and hearing therapists shall meet all the requirements for the special certificate in speech and hearing therapy as established by the State Board of Education.

(2) Speech and hearing therapists shall possess acceptable speech patterns and be able to hear within normal limits.

Chapter 7

DIVISION POLICIES RELATING TO STATE BOARD OF EDUCATION PROGRAM STANDARDS

Division Policy on Fractional Units

Under standards adopted by the State Board of Education in 1966, fractional units for Speech and Hearing Therapy may be approved by the Division of Special Education. The following policies have been adopted by the Division of Special Education to administer these standards:

(A) (1) A special education unit or fractional unit may be approved for speech and hearing therapy only within these standards.

(A) (3) One special education unit in speech and hearing therapy may be approved for the first 2,000 children enrolled in grades K-12 in a school district.

(A) (4) Additional special education units in speech and hearing therapy may be approved for each additional 2,500 children enrolled in a school district in grades K-12.

A fractional unit in Speech and Hearing Therapy may be approved under these standards when:

1. The individual is employed as a full-time speech and hearing therapist in one or more school districts.
2. The individual is employed part time as a speech and hearing therapist and is not gainfully employed in areas other than speech and hearing therapy.
3. The remainder of the individual's time is spent in speech and hearing therapy in a speech clinic or in private practice.

The number and size of buildings and amount of travel between them are factors to be considered in approval of fractional units in speech and hearing therapy.

Approval of fractional units is based on school enrollments, and may be computed as follows:

1. For school districts with less than 2,000 children enrolled in grades kindergarten through twelve:

Unit	Enrollment
0.2	400 - 499
0.3	500 - 699
0.4	700 - 899
0.5	900 - 1099
0.6	1100 - 1299
0.7	1300 - 1499
0.8	1500 - 1699
0.9	1700 - 1899
1.0	1900 + ----

2. For school districts employing more than one therapist and having more than 2,000 children enrolled in grades kindergarten through twelve:

Unit	Enrollment
0.2	500 - 624
0.3	625 - 874
0.4	875 - 1124
0.5	1125 - 1374
0.6	1375 - 1624
0.7	1625 - 1874
0.8	1875 - 2124
0.9	2125 - 2374
1.0	2375 + ----

Division Policy on Coordinators of Speech and Hearing Therapy

Under standards adopted by the State Board of Education in 1966, "school districts employing four or more speech and hearing therapists may designate one therapist as coordinator for technical assistance and professional guidance. The case load of such a therapist may be lowered on a pro-rated basis:" The following Division of Special Education Policy identifies the maximum time that may be assigned for coordination.

No. of Therapists	Units	Minimum Case Load
4-5	.2	60
6-7	.3	52
8-9	.4	45
10-11	.5	37
12-13	.6	30
14-15	.7	22
16-17	.8	15
18-19	.9	7
20-	1.0	—

Chapter 8

OVERVIEW OF SPEECH AND HEARING THERAPY SERVICES IN A SCHOOL SYSTEM

There are two parts to this chapter. "Functions of the Speech and Hearing Therapy Service Staff" should give the general school administrator an overview of the duties and objectives of a school speech and hearing therapy program. "Evaluative Criteria for a Desirable Program of Speech and Hearing Services in the Schools" will provide criteria for administrators and school speech and hearing therapists to judge effectiveness in terms of organization and program development. The first part is quoted from a publication overviewing the total program of pupil services in the schools entitled **The Organization of Pupil Services.**[1] The second part utilizes this publication as a base upon which to build. It should be emphasized that the following are not State Department of Education Program Standards, but go beyond these minimal requirements.

Functions of the Speech and Hearing Therapy Services Staff

The basic functions of school speech and hearing therapists are to:

I. Assist the school staff in the identification of children with speech handicaps.

II. Provide diagnostic services for children with speech handicaps. These problems include:
   A. Defects of articulation.
   B. Stuttering.
   C. Voice disorders.
   D. Disorders of speech and voice associated with organic abnormalities such as hearing losses, cerebral dysfunctioning and cleft palate.
   E. Speech disorders associated with delayed or disturbed language development.

III. Select children for habilitative services and provide appropriate speech therapy, auditory training and speechreading.

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[1] This Chapter is largely reprinted from the following publication: The Organization of Pupil Services, issued by E. E. Holt, Superintendent of Public Instruction, Ohio Department of Education, Columbus, Ohio, 1964.

IV. Assist children in the transfer of newly acquired skills to the classroom and the home by working with the children, their teachers and parents.

V. Consult with the professional staff of the school system in the development of appropriate in-service training programs for teachers and other staff on problems relating to speech, hearing and language development.

VI. Cooperate with school health personnel in the development of an appropriate hearing testing program.

VII. Cooperate with appropriate community agencies, resources and facilities concerned about children with speech and hearing handicaps.

Evaluative Criteria for a Desirable Program of Speech and Hearing Therapy Services in the Schools

I. Organization:

A. The school speech and hearing therapist holds at least the provisional certificate in the area, and is assigned on a full-time basis to speech and hearing therapy services in the schools.

B. There should be at least one full-time speech and hearing therapist for each 2,500 children enrolled in grades kindergarten through twelve.

C. The number of separate school centers in the school system in which the therapist is scheduled is dependent upon the method of scheduling selected:

1. When the traditional method of scheduling is utilized, the therapist should work in not more than four separate centers.
2. When the intensive cycle method of scheduling is utilized, the therapist should work in not more than two centers during any one cycle.

D. Each speech and hearing therapist should have a desk in an office centrally located with respect to the administration and other special services and secretarial services and secretarial services should be available when needed. Facilities for private conferences and interviews should be available.

E. In each building the speech and hearing therapist should be provided with a small room with adequate facilities free from distracting materials and sound.

F. The speech and hearing therapist should be supplied with appropriate equipment, materials and supplies.

G. The speech and hearing therapist is assigned as a staff person and does not carry administrative authority or responsibility for the operation of the school program.

H. The speech and hearing therapist is responsible to an administrative officer who is actively engaged in the coordination of pupil services.

I. There is a general bulletin in the school district describing the speech and hearing therapist's responsibilities, role, function and procedures.

J. Personnel policies encourage the speech and hearing therapist to participate in area, state, and national meetings of professional organizations of speech and hearing therapists.

K. Personnel policies encourage the speech and hearing therapist to continue graduate work in speech and hearing therapy and education.

L. The organization of speech and hearing therapy services in the school conforms to the principles of ethical standards of the American Speech and Hearing Association and the National Education Association.

II. Program:

A. Children with speech handicaps are identified through routine speech surveys conducted by the speech and hearing therapist and supplemented by teacher referrals.

B. Children with hearing problems are identified through routine and periodic screening coordinated by school health services and referred to the speech and hearing therapist.

C. Children are selected for therapy by the speech and hearing therapist on the basis of careful evaluation of the child and the seriousness of his handicap.

D. The total case load is well balanced and contains a number of types of speech problems. Articulation problems should not exceed seventy-five percent of the total case load.

E. The speech and hearing therapist works continually with classroom teachers to provide for "carry over" into the regular classroom.

F. The speech and hearing therapist confers with parents to provide "carry over" into the home.

G. The speech and hearing therapist maintains complete and accurate records on each child in therapy.

H. There are structured procedures for evaluation of the effectiveness of the service.

  (1) A regular follow-up check is made of all children dismissed from therapy.

  (2) A periodic analysis of therapy load is conducted.

  (3) Periodic evaluation of the program and service is conducted by the staff or by outside consultants.

I. The speech and hearing therapist is active in serving as a consultant to classroom teachers and other school staff on matters relating to speech problems, normal speech development, speech improvement, and hearing conservation.

J. The speech and hearing therapist schedules at least one half day per week for activities included in items g through i above.

Chapter 9

EQUIPMENT AND FACILITIES

Since school districts are making investments in terms of salary and other benefits to speech and hearing therapists, it is of considerable importance to assure that adequate facilities and equipment are made available so that speech and hearing impaired children are most adequately served.

In general, school speech and hearing therapists serve centers in several school buildings. An office in a central location in the school district should be provided. Since parent conferences, diagnostic work with some students, and sometimes actual therapy is provided in the central office, there should be adequate provisions for privacy. In addition, since it is frequently necessary to discuss over the telephone confidential information with medical personnel, mental health workers, or parents, a telephone should be located in this office. Filing cabinets which can be locked should be made available to protect the privacy of confidential records. Cabinets and shelves, desks, bookcases, and chairs are considered necessary. Secretarial service is necessary for assistance in preparation of materials used in therapy and for typing letters and reports. Provision for duplicating and mimeographing materials should also be made.

It is strong philosophy in Ohio that therapists can best service students by going into the actual school buildings where speech and hearing handicapped children attend, rather than providing therapy for these children from a central office or clinic. It is further felt that an intregal part of the functioning of a therapist revolves around the necessity of working closely with teachers and parents of children on the case load.

Therefore, in each school building served by a speech and hearing therapist, it is essential that a speech room be assigned, preferably in a location allowed easy entrance and egress of students from their regular class. This room need not be a large one, and may be utilized for other purposes when the therapist is not utilizing it. As a minimum, this room should have space to comfortably accommodate a therapist and five students. A table and sufficient chairs for students and therapist are essential. It should also be quiet, well-ventilated, adequately lighted, and free from distractions, since the very nature of the process of speech and hearing therapy requires this as a minimum. Electrical outlets should be provided for tape-recorder, audiometer and the like. A bulletin board, a permanent or portable chalkboard, and a large mirror mounted so that the students may sit before it are a portion of the minimal state standards.

Once a schedule for therapy services is established, it is important that it be strictly adhered to, especially if the room is also utilized by other personnel. It is also good to maintain a strict schedule since teachers will better know where to find the therapists for consultation. The children also become more accustomed to going to a particular room at a particular time.

Further, school districts need to make available one portable individual pure tone audiometer for the use of the speech and hearing therapist. A speaker attachment should be included for use as auditory training unit. The audiometer should be calibrated annually, and in no case should more than three years transpire before this is done. It is recommended that calibration be made to International Standards Organization specifications. As a minimum, school districts need to also make available one portable tape recorder for use in therapy. There are other materials such as film strips, speech games, and workbooks that speech and hearing therapists will also need to replenish each year.

Following is a summary of the basic equipment and materials that speech and hearing therapists need in operating an effective program of services to handicapped children:

Item	Number Per Center
Table	1
Chairs suitable for children	5
Chair for therapist	1
Bulletin board	1
Chalkboard (permanent or portable)	1
Mirror (large, mounted to permit students to sit before it)	1
Tape recorder	(access to one)
Record player	(access to one)
Audiometer (individual portable pure tone)	(access to one)
Locked cupboard, drawer space, or filing cabinet	1

Additional equipment generally includes:

- hand mirrors
- record albums
- workbooks
- speech games
- scissors
- speech tests
- professional books
- films and filmstrips
- flannel board
- assorted colored paper
- toys
- flash cards
- blank playing cards
- directories for referral sources

A realistic budget for such non-fixed equipment would be between $20.00 and $40.00 per year. Lists of suggested equipment and materials may be obtained by contacting the Educational Consultant, Speech and Hearing Therapy, Division of Special Education, Ohio Department of Education, Columbus, Ohio.

Chapter 10

ORGANIZATION OF PROGRAM

The organization of classes for speech and hearing therapy services is dependent upon a number of factors:

1. Identification of students
2. Nature of the community
3. Severity of problems identified
4. Availability of community resources and supportive personnel in the school district
5. Age, grade level, maturity, and ability of students
6. Professional training and competencies of the therapist

Depending upon these variables, the speech and hearing therapist generally groups children according to similarity of problem and general level and maturity. The advantage is that the therapist can work on specific sounds, for example, and arrange speech activities in such a manner as to provide opportunity to transfer the particular sounds. The size of the group should in no case exceed five, and in many cases be considerably less. With large groups, it is extremely difficult to plan, develop, and execute appropriate lessons and techniques to meet the needs of each child in the class.

Especially if the problem is severe, some children will need intensive individual instruction. This is generally true if the child is particularly sensitive or if his problem is such that if larger classes were formed much of its time would be spent in special instruction for the one child.

It is much better for a therapist to do an adequate job with a smaller group size or case load than to distribute services over such a wide area that good results are difficult to obtain. Just enrolling a child for therapy does not necessarily achieve results. State Board of Education Program Standards limits both the maximum and minimum size of classes, number of centers, and case load to try and insure the most effective use of the therapists' time. Organization of classes must take account of these factors.

Identification of Students

As with all programs dealing with handicapped children, identification of children with speech and hearing handicaps should be provided as early as possible so that the most effective habilitation can commence. Many studies indicate that, within reasonable limits, the earlier treatment begins the greater the probability of success under treatment. Ohio's therapists work primarily at the elementary school level.

For speech problems, a survey conducted by the therapist is much more practical than one utilizing teachers or other school personnel since many speech disorders are thus overlooked. In general, most therapists screen kindergarten and first grade children in smaller schools, or at least second graders and new students in larger schools. Teacher referrals in other grades are often utilized. Because of the large number of students to be screened, it is important that a screening method be developed by the therapist using no more than one or two minutes per child. With identified speech problems, a much more detailed evaluation is recommended.

Although in Ohio only about two percent of the typical therapist's case load is composed of hearing impaired children, speech and hearing therapists have a considerable role in identification and referral of these children to the appropriate specialists. Chapters 14 and 15 discuss the hearing program in greater detail. Suffice to say that according to Ohio law, school systems must determine the existence of hearing defects in school children utilizing evaluation devices and procedures approved by the Ohio Department of Health or the school physician.

Thus Ohio law specifically states that the responsibility for hearing testing rests with either the school physician or the local board of health. This responsibility includes the audiometric evaluation, and the examination is generally done by a nurse or trained para-professional.

School speech and hearing therapists are frequently involved with the nurses in threshold testing, and a close coordination with the school or department of health nurse is recommended. During 1967-68, therapists averaged 33.0 audiometric screenings, completed a mean of 1.5 threshold tests.

Minimal screening recommended by the Ohio Department of Health for the estimated two and one-half to three percent of hearing impaired children includes all children in grades 3, 6, and 9; new students; and referrals by nurses and teachers.

Screening could easily become a never-ending process if lengthy screening procedures are involved. In school speech centers having services the preceding year, no longer than a week should be involved in screening and establishing initial groups for therapy. In school systems not having prior services of a speech and hearing therapist, enough of the children where centers are to be located can be adequately screened and therapy begun in two to not more than three weeks.

It should be further emphasized to the new therapist, that screening procedures should be discussed in considerable detail with school administrators to insure that the program operates smoothly and with the full understanding and support of administration and teachers.

After screening, the therapist's case load should only be selected only on the basis of a complete diagnostic speech test (including an evaluation of the oral mechanism) and thorough audiometric examination (either rechecked or given initially by the therapist). Referrals should be made to the school or family physician if medical evaluation is warranted. Psychological or psychiatric recommendations should also be solicited if indicated prior to selection of the case load.

Nature of the Community

The manner in which the program is organized and even the type of cases selected is dependent upon the nature of the community involved. For example, where a shortage of personnel exists, most school administrators give a high priority to serving just the early elementary level students. In some large urban areas with adequate staff-pupil ratios, therapists sometimes specialize in dealing with senior high school students, working with handicapped children in special classes (orthopedically handicapped, educable mentally retarded), or with related specialized difficulties. In many suburban areas, there is an unusually high preponderance of neurologically impaired children, while in some urban areas more than ninety percent of the students have difficulties which can be alleviated by a therapist who can serve as a consultant to speech improvement programs in addition to regular duties.

Severity of Problems Identified

In general, the more severe and complex the problems identified, the smaller the class size the therapist will be able to effectively schedule. For example, 88.15 per cent of the tpyical therapist's case load is composed of articulatory problems.[1] Obviously a larger case load can be handled with these problems than if the case load is predominantly composed of children with a cleft palate or cerebral palsy.

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[1] During the 1967-68 school year, case loads also included the following categories: (1) disorders of rhythm (3.8%); (2) disorders of language (3.9%); (3) hearing impaired (1.8%); (4) disorders of voice (1.3%); (5) cleft palate (0.8%); and (6) cerebral palsy (0.6%).

Availability of Resources

The organization of classes and selection of case loads will reflect the availability of both community resources and supportive personnel in the school district. In some cases, it might be adviseable to refer certain cases to special clinics, hospitals, otologists, and others for more specialized and detailed evaluation and treatment. If a therapist is employed close to a major metropolitan area, the availability of community resources is greatly increased. Each therapist should compile a directory of such community services which includes basic functions, admissions policies, fee schedules, operational procedures, and the like. The therapist may want to make a determination relative to the overall program of each agency before recommending that a child is referred. Often other therapists in the area may be of assistance in this respect. Sometimes the local United Appeals, Council of Social Agencies, or universities in the area have compiled such useful data which speech and hearing therapists can obtain. Depending upon the background and training of the school therapist, the school speech and hearing therapists should be careful about making referrals of difficult cases to outside agencies because (1) it is difficult to follow-up these children and insure that services are actually being obtained; (2) expense in time and money for parents may be great; and (3) lengthy waiting lists at some agencies.

Outside the major metropolitan areas, the therapist may have few, if any, immediately available referral sources. Case loads in these areas frequently include more difficult cases as a result.

Therapists should not forget that there are increasing numbers of specialists, particularly in the areas of pupil services, that are being employed by local school systems. They may be excellent referral sources which could easily be overlooked. In such school systems, there should be close and continual professional communication on cases and programs between school psychologists, guidance personnel, school nurses, visiting teachers, school social workers, supervisors of special education programs, and directors of pupil personnel services. Increasingly, departments of special education and/or pupil services are developing in school systems, particularly the larger ones, which consider speech and hearing therapy an integral aspect of a developed program for handicapped children of all categories.

School psychological evaluations, home visitation programs, and the liaison with medical personnel which nurses sometimes provide are examples of services that are being provided in more and more school systems which can be of major help to a therapist in understanding her cases. Conversely, the therapist often has information which can be of assistance to other specialists in their work. In any case, therapists should not overlook either outside referral sources or professional personnel in their own districts which can assist the therapist in working with handicapped children.

Administrative assistance to speech and hearing therapists, especially in terms of development of program on a "team" basis has been increasing. During the 1965-66 school year 57.6 percent of therapists were being supervised by administrators who in most cases can be assumed to have a basic knowledge of the role and function of the school speech and hearing therapist.[2] Increasingly, therapists are being housed in a defined pupil personnel and/or special education department in proximity with other specialists who can offer assistance in terms of referral agencies, supportive services, background information, and specialized help for the child.

Level of Student

The majority of school speech and hearing therapists identify more students than can be programmed for services during the school year. Therefore, the therapist must establish certain criteria for selecting those children who can be served most effectively. Although the school superintendent has the legal authority to assign any student to any program he deems adviseable, in virtually all cases he designates the school speech and hearing therapist to make the selection of individual cases. Although the decision is usually a difficult one because of the individual differences found in students, school systems, and the training and competencies of the therapists involved, some basic guidelines are suggested:

I. Prognosis: This is often very difficult to determine because such factors as attitude of the student, his friends and parents, degree of organic involvement, native ability, and consistency of substitutions in articulation are all important factors. If in the therapist's judgment prognosis is very poor, a judgment should in general be made on the basis of doing the greatest good for the most students possible.

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[2] 18.3% were supervised by directors of special education; 24.5% by directors of pupil personnel; 10.7% by senior speech therapists, and 4.1% who had a combination of the above titles. 40.5% were directly responsible to a staff member with a general administrative background. Disturbing was the 1.9% of therapists who had no idea who their direct supervisor was.

II. Native ability: As a general principle, children with the lowest mental age have the greatest difficulty in profiting from therapy. Many experts consider that a mental age of six can be an effective guideline if services need to be limited, although other factors such as motivation, indedependent study skills, emotional adjustment, and home and community environment are also important. It is suggested that some educable mentally retarded children (intelligence quotients of 50-80) be a part of the case load if special services are needed. However, the therapist's greatest general contribution to these children may be made during coordination time or after school as a consultant to special teachers and parents so they can develop and maintain a consistent speech improvement program. It is not the function of the therapist to provide speech improvement, but he can be a highly effective resource in this area.

III. Hearing: Auditory problems make up slightly less than two percent of the case loads of Ohio's therapists, yet should be given major priority for service. Children who are in need of speech reading and auditory training must have service if normal educational growth and development is to occur, especially if the hearing loss is progressive or severe enough to interfere with normal learning.

IV. Severity of the problem: The degree of severity of any speech or language problem is difficult to determine, and must of necessity be highly dependent upon the judgment of the therapist. For example, seemingly minor psychogenic problems placed on a waiting list may have serious and increasing social and emotional disturbances. Although the therapist must continually guard against such cases, it is felt that if limitations of size of case load must be made, it is usually best not to eliminate problems of organic etiology.

V. Maturity: Therapists need to have a considerable background in child and adolescent growth and development, especially as this relates to the speech and hearing mechanisms. A thorough knowledge of language development is necessary especially as it relates to changes in mental maturity. Since articulatory problems are the cause of almost eight of every ten children on the case load of Ohio's school therapists as now selected, and three of every five children enrolled is in grades kindergarten through twelve, it is possible that many of these children have minor problems which will disappear normally due to maturation. Therefore, considerable discretion should be used in enrolling young and immature students with minor articulation problems for therapy.

Competency of the Therapist

When any program of services is organized and the case load selected, one of the most important variables for a school speech and hearing therapist is his general professional background and specific competencies. In large school systems, supervisors of speech and hearing therapy programs often place therapists in school situations geared to these competencies. In smaller districts, the therapist may be asked to serve all language handicapped children in his community, regardless if he has had training or skill to deal with a specific type of problem.

Therapists should be very careful to recognize his area of competency and refer problems outside his skills to appropriate specialists, if available. In addition, the Code of Ethics of the Ohio Speech and Hearing Association states that it is unethical "to attempt to deal exclusively with speech and hearing patients requiring medical treatment without the advice of or on the authority of a physician."

The field of speech and hearing therapy is changing very quickly. New concepts, methodology and diagnostic instruments are continually being developed. In order for a therapist to remain professionally competent and deal with a realistic variety of communication problems in the schools, continual attempts to keep informed of new techniques and materials is essential. Membership in professional organizations, academic work, and subscriptions to pertinent journals is essential to this endeavor.

General Consideration

When a program is organized and the case load selected, school speech and hearing therapists should be cognizant of the following:

I. If a child is receiving care from a psychiatrist, psychologist, or related mental health workers, he should not receive therapy unless it is specifically recommended by the specialist handling the case. Therapy may in some cases be harmful. At times the specialist may also be able to give guidelines which will help the therapist work with the child better.

II. If a child is receiving speech and hearing therapy on a private basis, he should not be enrolled in a class by the school speech and hearing therapist until after private treatment has terminated.

III. Children who are physically unable to attend school even with the aid of transportation may be served by the therapist if home instruction (academic tutoring) is being provided for these educable children.

IV. School speech and hearing therapists cannot ethically assume a private practice which provides service to children in his school district who would be entitled to any assistance through the school program.

V. Children who attend schools near a school speech center may be transported to that center for special assistance. Before such a plan is initiated, the therapist should be cognizant of the time a student so transported would not be in regular school attendance, general transportation arrangements that will need to be made, local board of education policies, and general liabilities attendant to transporting students from one building to another.

Chapter 11

INSTRUCTIONAL PROGRAM

After initial screening and diagnostic evaluations are completed, it becomes necessary to systematically plan which students become a part of the active case load in each speech center. Since speech and hearing services are usually of an itinerant nature, a time schedule should be developed and approved by each administrator involved so that scheduling conforms with the operational program of the buildings. Therapists, therefore, must develop schedules which also consider other factors than just the number of problems and extent of student difficulties which have been identified. The following additional factors need to be considered when schedules are developed:

1. General school schedule (recesses, lunchtime, regular extracurricular functions, bus schedules, starting and closing time of the building).
2. Speech center scheduling (what other specialists utilize the therapy room, and when).
3. General school calendar (vacation schedules, teacher work days).

The therapist then should develop in cooperation with pertinent personnel, a specific schedule of activities which can be made available to teachers and administrators. This schedule might include the following:

1. Days present at each speech center.
2. Name of each student enrolled for therapy, as well as his grade, room, and teacher.
3. Coordination day.
4. Exact time of therapy for each student.
5. Name, telephone number, and central office address where a therapist can be located.

A therapist may wish to develop either one master schedule incorporating all of the above factors or establish two distinct types of schedules: (1) a permanent one showing the dates and times a therapist will be in each center; and (2) a schedule for a specific building indicating each student enrolled, grade, room, name of teacher, and exact time of therapy. In the latter case, the therapist can easily revise each speech center's schedule as needed.

Scheduling Method

In Ohio, two distinct methods of scheduling are incorporated in the state program standards (see Chapter 6). Either the traditional or intensive cycle methods of scheduling should be utilized, although recent research indicates a combination of scheduling may be optimum.

The *traditional method* of scheduling basically requires a minimum of twice weekly therapy sessions for each elementary school student on the case load until each child is either dismissed or obtains maximum improvement. Once a week sessions are permitted for high school students. The number of centers in which a speech therapist works is determined by the enrollment of the building and needs of the children. Not more than four centers are recommended, and according to state standards not more than six centers shall be established. Active case loads vary between 75 and 100 children at any one time. This method was the only one utilized in Ohio over the last two decades, and resulted in corrections or dismissals from therapy of between thirty and forty percent per year. Presently, approximately ninety percent of Ohio's school speech and hearing therapists use the traditional scheduling method.

Personnel interested in speech correction in Ohio suggested that perhaps other methods of scheduling should be explored in the hopes that a larger number of cases could be dismissed from therapy and a greater total number of students served.

Ohio State Board of Education Standards adopted in 1962 made provision of the approval for state reimbursement units for experimental programs designed to provide a "new or different approach to the techniques and/or methodology related to speech and hearing therapy." This provision provided an opportunity for the Division of Special Education to explore with local school districts the value of new approaches to scheduling. Between 1962 and 1966, Brecksville, Cleveland, Dayton, East Cleveland City Schools and the Crawford County Schools explored the intensive cycle method of scheduling. As a result of this research, the State Board of Education revised its program standards in 1966 to permit this method of scheduling as an alternate to the traditional one.

When the *intensive cycle method* of scheduling is adopted, at least four half days per week are scheduled in each center, usually on a consecutive basis. The remaining one-half day is used to follow-up cases in previous cycles where continued treatment is indicated. Each center must be scheduled for a minimum of two to a maximum of four cycles per year, insuring that students are seen in blocks of time at least twice a school year. The individual intensive cycles scheduled at a particular center shall not be consecutive, but shall alternate with time blocks in other centers. The length of each cycle should be at least five to a maximum of ten consecutive weeks. Usually, the first cycle in a center is longer to provide sufficient time for screening, selecting pupils, and initiating the program.

As with any scheduling method, there are distinct advantages and disadvantages that develop. On the basis of research data in Ohio schools, the following are noted in this respect:

I. General advantages:
  A. A greater number of children could be enrolled during the school year.
  B. A larger percentage of children were dismissed from therapy as having obtained maximum improvement.
  C. The length of time children with articulatory problems were enrolled in speech therapy was reduced.
  D. Although not statistically significant, the Brecksville study gave some indications that a greater carryover of improvement occurred.
  E. Closer relationships between the therapist and school personnel and parents was noted due to the greater acceptance of the therapist as a specific part of a particular school's staff.
  F. Students appeared to sustain interest in therapy over a longer period of time.
  G. Less time was needed in reviewing a lesson since daily therapy sessions occurred.

II. General problems:
  A. Some difficulties of a psychogenic nature may need more frequent contacts on a regularly scheduled basis.
  B. Administrative problems and reactions to students leaving a classroom on a daily basis may be a problem if the intensive cycle program is not carefully explained to the school staff.
  C. Monopolization of a shared room for therapy services may cause scheduling problems.

D. Presently, therapists in Ohio have no real training in working with intensive cycle scheduling, and adjustment may be difficult. Student teaching in intensive cycle scheduling is presently difficult to obtain.

The actual method of scheduling selected depends upon the therapist's interest and inclinations as well as the identified needs within the local school district. Either the traditional or intensive cycle methods of scheduling may be used.

Lesson Planning

After careful selection of the case load, perhaps the most important problem facing the therapist is the development of effective lesson plans. A great deal of outside preparation is necessary to develop appropriate plans for each child on the case load which take into account the diagnosed problem as well as the child's general maturity, severity of the problem, general ability, motivation, and prognosis. These lesson plans should be written, and include besides general goals and objectives the specific methods, techniques and materials to be utilized each day with each child. Individual differences need to be taken into account, and techniques and materials should vary from child to child and from group to group. It is often useful to integrate lesson plans with subject matter in the regular class. Although this is often difficult to do because of the itinerant nature of scheduling speech and hearing therapy services, it is considered to be essential. Some therapists have presented materials above the reading level of students either in therapy or on practice lists given to work on newly acquired speech patterns at home. In general, material to be read by a student in therapy should be one to two years below his general reading level to insure that he can read it with reasonable ease.

By coordinating lesson plans with regular classroom learning, both academic learning and the idea that improved speech skills are useful outside of therapy sessions are reinforced. Spelling lists, arithmetic problems, and general reading materials are usually easy to obtain from the classroom teacher.

Not only should the therapist plan ahead of time the specific lessons to be used in therapy, he also should be careful to plan that therapy materials are available before sessions commence. In addition, brief records of the results of therapy and techniques which might be useful in the future should be maintained.

Especially for younger children, charts and graphs showing individual progress can be an important and effective motivating device. Students can then see how well they are developing good speech patterns, and the fact that what is being done in therapy has a definite positive effect can more easily be noted.

Carry-over

One of the difficulties inherent in any speech and hearing therapy program is that students generally spend less than one percent of their time in any one week in therapy. Unless the student actually practices his developing speech patterns outside of therapy, the time spent with the therapist will be of little avail. Therefore, it is very important that the therapist make well-planned provisions for the child to practice his new speech patterns at home and school. Improvement is directly dependent upon the motivation of the individual child to practice and the willingness of other personnel to help.

School speech and hearing therapists may wish to use commercial workbooks or develop their own to be used in carry-over activities. Contact with the parents and continual follow-up with them is of help if the parents are motivated and if they do not have speech defects that would be incompatible with working with the child. Therapy aides, teachers, and even other students may upon occasion be valuable to this endeavor, particularly if the therapist has a well-designed and carefully considered plan to help these interested parties help the child.

Termination of Therapy

The final judgment of when students are to be dismissed from the case load usually rests with the individual therapist. Dismissals result when a child has reached maximum improvement, or when in the judgment of the therapist further work with the child will yield minimal results. Dismissals may be because of a variety of reasons: the child's speech pattern may be considered corrected, for example, or his motivation might be so low as to render further therapy of little use.

The therapist should give as much consideration when a child is to be discharged from therapy as when the original selection for service was made. In most cases, the therapist will wish to reevaluate the student's speech and/or hearing difficulties when therapy is terminated. He may wish another therapist to evaluate the child to confirm his judgments. He should in any case notify the parents and school personnel that therapy is being stopped, and why. Additional counseling with the student, his parents, or teacher may be indicated in many instances, particularly if suggestions for future needs are made. Often, the therapist may wish to gradually taper off the number of therapy sessions when considering dismissing a child from therapy. This is most appropriate when the child needs only occasional reinforcement to insure that good speech patterns are continued, or if the child has become dependent upon the therapist for emotional support.

When therapy is terminated, a permanent record should be made relative to diagnosis, progress through therapy, and duration of services.

Follow-up of Cases

Periodic assessment of children dismissed from therapy should be made over at least a two year period. Follow-up should be done in a systematic manner. Coordination time lends itself in particular to this activity. When therapy is terminated, the child should be checked approximately two to three months later to insure that progress has been maintained. If no problem exists at this time, a cursory evaluation about a year later will be sufficient to place the case folder or card in the therapist's inactive file.

Frequently, students have been identified as candidates for speech therapy but because of insufficient staff cannot be included in the program. These students should be re-assessed at least once each year until adequate services can be provided. A current "waiting list" should be maintained by the therapist.

Follow-up is also relevant in cases where children have been referred to other agencies. Many agencies are happy to supply progress reports and recommendations for school action to the school speech and hearing therapist. In addition, some agencies are most appreciative if the school therapist can provide periodic progress reports relative to school behavior of the child.

Chapter 12

RECORDS AND REPORTS

It is expected that each therapist shall maintain adequate records of all students, including those screened, those presently a part of the case load, those waiting for therapy, and those dismissed from therapy. In order for a program of speech and hearing services to perform at an effective level, periodic reports to keep administrators, teachers, and parents informed of progress and basic needs should also be made.

It is not expected that lengthy and detailed records be kept for each child. Records should be concise, accurate, easily accessible to the therapist, and be kept in a locked file if confidential information is included.

It is recommended that when a child is enrolled for therapy, his parents or guardian are contacted so that both permission for therapy and mutual information can be obtained. Periodic written and oral reports to parents should be made. Home visits or conferences at school are encouraged so that parents can learn more about the nature of the child's handicap and ways in which they might help at home.

In addition, a report to the classroom teacher, generally oral in nature, can provide him with information about how to help the child. This is also a good method of learning how well a child is progressing outside of the therapy situation.

Principals of buildings in which speech centers are located are generally most appreciative of periodic oral reports of progress or difficulties encountered with particular children. A brief written report concerning case loads in the particular center should be made at the end of each semester, and should include such data as: (1) students dismissed; (2) students enrolled; (3) children on a waiting list; and (4) a short statement of the progress of each child receiving therapy.

The administrator directly responsible for supervision of speech and hearing therapy services should be continuously informed of pertinent developments in the program. An annual report to the administrator should be made in a concise manner. Items included in such a report might be:

1. Statistical data: Number of students screened; enrollment in classes by level and type of problem; number dismissed

from therapy; total on the waiting list; and number to be continued in therapy during the coming year.

2. Descriptive data: Inservice training programs, special projects, attendance at professional meetings, and the like.
3. Recommendations: Suggestions for improving the program of services should be included.

An annual report of speech and hearing therapy services is required by the Ohio Department of Education. An example of this report may be found in Appendix A. All school speech and hearing therapists should receive a similar annual report form from the Division of Special Education by late May of each school year.

Chapter 13

SOURCES OF PROFESSIONAL ASSISTANCE

It is essential that school speech and hearing therapists become familiar with potential sources of assistance at both the state and local levels. Therapists will frequently be asked where children with specific types of handicaps can be referred. Some of the agencies most pertinent for those interested in speech and hearing impaired children are listed below:

State Sources

Educational Consultant
Speech and Hearing Therapy
Division of Special Education
Ohio Department of Education
3201 Alberta Street
Columbus, Ohio 43204

Medical Director
Bureau of Crippled Children
Services
Ohio Department of Welfare
527 South High Street
Columbus, Ohio 43215

Chief, Hearing and Vision
Conservation Unit
Ohio Department of Health
450 East Town Street
Columbus, Ohio 43215

Director
Bureau of Vocational
Rehabilitation
Ohio Department of Education
240 South Parsons Avenue
Columbus, Ohio 43215

Executive Director
United Cerebral Palsy of
Ohio, Inc.
601 Commercial Building
Dayton, Ohio 45402

Ohio Society for Crippled
Children and Adults
311 Kendall Place
Columbus, Ohio

Training Universities

There are speech and hearing clinics in the eight universities in Ohio approved by the Division of Teacher Education and Certification for the preparation of school speech and hearing therapists. Although there are some differences in terms of general organization and operating policies, the therapist may find occasion to use the university sponsored clinic as a referral source, especially if a more intensive diagnosis and treatment than a therapist is qualified to give appears warranted. Inquiries may be made at the following universities:

Director, Speech and Hearing
Clinic
University of Akron
Akron, Ohio 44304

Director, Speech and Hearing
Clinic
Bowling Green State University
Bowling Green, Ohio 43402

Director, Speech and Hearing
Clinic
Case-Western Reserve University
Cleveland, Ohio 44106

Director, Speech and Hearing
Laboratories
Old Commons Building
University of Cincinnati
Cincinnati, Ohio 45221

Director, Speech and Hearing
Clinic
Kent State University
Kent, Ohio 44240

Director, Speech and Hearing
Clinic
322 Derby Hall
Ohio State University
Columbus, Ohio 43210

Director, Speech and Hearing
Clinic
Miami University
Oxford, Ohio 45056

Director, Speech and Hearing
Clinic
Ohio University
Athens, Ohio 45701

P.O.D. Clinics

The Ohio Department of Health has been instrumental in establishing regional Pediatric Otological Diagnostic Centers in many areas of the state. The centers are staffed by a pediatrician, otologist, speech clinician and audiologist, and children may be referred for evaluation through the local city or county health department. Some counties do not participate in the P.O.D. Clinic. Children in such regions may be scheduled into the nearest clinic by contacting the Chief of the Hearing and Vision Conservation Unit, 450 East Town Street, Columbus, Ohio 43215.

Saturday Clinics

Through the Ohio Department of Health a number of "Saturday Clinics" have been established throughout Ohio. All ages may be served by these clinics, and fees are adjusted to ability to pay.

Hearing Conservation

The chief responsibility of the therapist is to do speech therapy, and he cannot be expected to do extensive hearing screening.

Nevertheless, he should work closely with his school nurse or health department to develop an effective hearing testing program. If no such program exists, he may wish to work with school and health personnel to develop a hearing conservation program. Consultive advice, forms, literature, and general support may be obtained from an Ohio Department of Health Hearing and Vision Consultant in the following locations:

Northeast District Office
2025 Second Street
Cuyahoga Falls, Ohio

Northwest District Office
133½ South Main Street
Bowling Green, Ohio

Southeast District Office
Box 150
Nelsonville, Ohio

Southwest District Office
310 Ludlow Street
Dayton, Ohio

Ohio Department of Health
450 East Town Street
Columbus, Ohio

Professional Organizations

It is important that all professional personnel continue their education through in-service education, publications, and program development. Members in these professional organizations can also provide consultant services to local speech and hearing therapists under certain conditions:

I. American Speech and Hearing Association:

Information relative to membership and A.S.H.A. certification can be obtained by contacting the Executive Secretary, American Speech and Hearing Association, 9030 Old Georgetown Road, Washington, D. C. 20014. School therapists who hold the bachelor's degree may be permitted to join the A.S.H.A. journal group.

II. Volta Bureau:

Alexander Graham Bell founded the Volta Bureau in Washington, D. C., as an information center on deafness and the education of the deaf. Inquiries may be addressed to 1537 35th Street, N.W., Washington, D. C. It publishes the proceedings of the Alexander Graham Bell Association for the Deaf, Inc., as well as books and pamphlets concerned with deafness, speech, language, and related subjects.

III. National Association of Hearing and Speech Agencies:

Located at 919 18th Street, N.W., Washington, D. C., this organization has almost 200 member organizations in the United States interested in communication handicaps affiliated with it. Many local and state hearing centers and university clinics are affiliated. Individuals may now obtain membership.

IV. Ohio Speech and Hearing Association:

Membership in the American Speech and Hearing Association is not a pre-requisite to membership in O.S.H.A. Information relative to membership may be obtained by contacting the organization's secretary, Dr. Melvin Hyman, Director, Speech and Hearing clinic, Bowling Green State University. Besides professional meetings, O.S.H.A. publishes a *Newsletter* and the *Ohio Journal of Speech and Hearing.*

V. Council for Exceptional Children:

Information concerning membership may be obtained by contacting the Council at N.E.A., 1201 Sixteenth Street, N.W., Washington, D. C. 20036 or the local chapter in your area. Many children with speech problems have difficulties in other areas, and this organization and its state and local chapters attempts to keep members informed of basic trends, issues, and research in all areas of exceptionality.

VI. Local Associations of Speech and Hearing Therapists:

Recently a number of local associations have been forming. For further information about the membership chairman of each of these groups, contact the Division of Special Education:

Central Ohio Speech and Hearing Association
Central State Speech and Hearing Association
Hamilton County Speech and Hearing Association
Mahoning Valley Speech and Hearing Association
Miami Valley Speech and Hearing Association
Northeast Ohio Speech Association
Northwest Ohio Speech Association
Portage County Speech and Hearing Association

Stark County Speech and Hearing Association
Summit County Speech and Hearing Association
Toledo Area Speech and Hearing Association

VII. General Local Sources:

School speech and hearing therapists should not overlook the many local groups interested in promoting child welfare. Some of these organizations have special funds which can be used to assist handicapped children. Although, these groups and their potential services vary throughout the state, each community area has a health department, welfare department, and medical society. Many have mental hygiene clinics and hearing and speech centers in addition to interested civic associations.

HEARING PROGRAMS

Chapter 14

OVERVIEW OF LOCAL PROGRAMS FOR THE HEARING IMPAIRED CHILD

The program of educating hearing impaired children is the oldest program in special education in Ohio. In 1822, county commissioners were authorized to appropriate money for the education of "deaf and dumb" children whose parents found it impossible to pay for their instruction. In 1898, a law was passed requiring cities to maintain schools for residents who were deaf or whose speech was so defective that normal school work was not possible. Legislation has since developed so that today there are a number of alternatives available for hearing impaired educable school children:

I. Educational programs for hearing impaired children:[1]
   A. Educable children are eligible for placement in a unit for **hard of hearing** children if they:
      1. Have a relatively flat audiometric contour and an average pure tone hearing threshhold of 50 dB or greater for the frequencies 500, 1,000 and 2,000Hz in the better ear (ISO-1964), or
      2. Have an abruptly falling audiometric contour and an average pure tone hearing threshold of 50 dB or greater in the better ear for the two better frequencies within the 500-2,000 Hz frequency range.
      3. Functions as a hard of hearing child and is approved for placement in a special education class by the Division of Special Education.
   B. Educable children are eligible for placement in a class for **deaf** children if they:
      1. Have a relatively flat audiometric contour and an average pure tone hearing threshold of 70 dB or

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[1] Note State Board of Education Program Standards in Appendix D. For further information, contact the Educational Consultant, Hearing Impaired, Division of Special Education, Ohio Department of Education, Columbus, Ohio.

greater for the frequencies 500, 1,000 and 2,000Hz in the better ear (ISO - 1964), or

2. Have an abruptly falling audiometric contour and an average pure tone threshold of 70 dB or greater in the better ear for the two better frequencies within the 500-2,000Hz frequency range (ISO-1964).
3. Functions as a deaf child and is approved for placement in a special education class by the Division of Special Education.

II. Speechreading and auditory training:
If hearing loss in the better ear is generally between 20 and 50 decibels, the speech and hearing therapist may consider initiating speechreading and auditory training. These children should be given a high priority on the therapists' case load since academic progress is highly dependent upon speechreading skills and the effective utilization of residual hearing. Speechreading and auditory training should not commence until a thorough otological examination is made, with copies of the report filed with both the nurse and the therapist.

In general, most classes for deaf and hard of hearing are located in the major metropolitan areas of Ohio. Inquiries about programs may be made to directors of special education in the communities involved or through the Division of Special Education. During the 1967-68 school year, there were 1,349 children served by 180 units for the deaf in 21 school districts. In addition, 26 units served 246 hard of hearing children in nine school districts.

Chapter 15

SPECIAL STATE PROGRAMS FOR HEARING IMPAIRED[1]

Educational Evaluation Clinic Team

Children to be considered for admission to the Ohio School for the Deaf are referred to the Educational Evaluation Clinic maintained by the Ohio School for the Deaf and the Division of Special Education. This clinic is held monthly throughout the year at the Ohio School for the Deaf. Hearing, psychological and educational evaluations are made without charge. Clinic appointments are made only upon request from the superintendent of the school district in which the child legally resides. Parents seeking an appointment should make their request directly to the local superintendent of schools.

Findings of the Educational Evaluation Clinic Team are reported to a Review Committee consisting of three members appointed by the State Board of Education. Membership on this Committee at the present time consists of the Director of Special Education, the Superintendent of the Ohio School for the Deaf and one member appointed by the Superintendent of Public Instruction. It reviews each case individually and makes a recommendation to the Office of the Assistant Superintendent of Public Instruction on the basis of the child's educational needs, the availability of suitable programs in the state, and the preference of the child's parents relative to educational placement. The recommendation from this latter office is sent to the superintendent of the local school district. He then has the responsibility for sharing both the findings and the recommendation with the parents and all members of the school staff involved in programming the child. He may also notify community agencies directly involved in implementing the recommendations.

Children may be referred for further examination and study to the Medical Clinic Team, consisting of a pediatrician, ophthamologist, otologist, otolaryngologist and a neurologist. The services of this team are provided through the cooperation of the Ohio Department of Health. This clinic is held monthly during the school year. A complete report of the Medical Clinic Team is forwarded to the Central Review Committee. Any further suggestions resulting from this medical evaluation will be sent in a written report to the local school district. All children referred to the medical clinic must have been seen initially by the Educational Clinic Team.

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[1] Speech and hearing therapists wishing to know more about programs for hearing handicapped are referred to the following publication: Hartwig, J. William, and Jones, Christina C., OHIO'S PROGRAM FOR HEARING HANDICAPPED CHILDREN. Columbus: Ohio Department of Education, 1966.

Children already enrolled in special education classes may be referred for evaluation by the Educational Evaluation Clinic Team if the local school authorities feel further study seems warranted.

Ohio School for the Deaf

In 1827, enabling legislation provided for the establishment of a Board of Trustees to initiate an "asylum for Educating the Deaf and Dumb." The first classes in the "asylum" were opened in 1829. After a number of moves, the present Ohio School for the Deaf was opened in 1953 at 500 Morse Road, Columbus, Ohio. At the present time, a total of approximately 250 children are being instructed at this residential facility.

In 1960, the State Board of Education adopted policies relative to admission and dismissal criteria to the School, and approved the establishment of the Educational Evaluation Clinic to insure better services to hearing handicapped children.

Admission procedures and criteria and factors considered in placement of students are outlined below:

A. Admission:
  1. Procedures
    (a) All deaf and all deaf-blind children will be referred to the Division of Special Education.
      (1) All referrals will be made by the school district of residency of the deaf or deaf-blind child.
      (2) The Division of Special Education will maintain a central file for all information concerning deaf children.
    (b) All deaf children referred will be seen by a staff clinic team for evaluation in the following areas:
      (1) Otological
      (2) Audiological
      (3) Psychological
      (4) Educational

        (5) Other special areas may be included when additional information is necessary to complete the evaluation.

    (c) The report of each child will be referred to the following committee:

        (1) Superintendent, Ohio School for the Deaf or his designated representative.
        (2) Director, Division of Special Education.
        (3) One member will be designated by the Superintendent of Public Instruction.

    (d) The committee recommendations will be submitted to the Superintendent of Public Instruction for appropriate action.

2. Criteria for Admission — Children may be admitted to either a residential or a day school program at the Ohio School for the Deaf:

    (a) If they have a severe through profound hearing loss in the speech range. This is a 70 decibel or more loss in the better ear (ISO-1964).

    (b) If they are capable of profiting substantially by instruction. This will be determined by the standards adopted by the State Board of Education under Section 3321.05 R.C.

    (c) If they have sufficient physical and social maturity to adjust to the discipline of formal instruction and group living.

3. Placement — Factors that will be considered in placement of children are:

    (a) Availability of a suitable local school program.

    (b) Needs of individual children.

    (c) Parental preference.

Chapter 16

AUDIOMETRIC EVALUATIONS

Participation by the school speech and hearing therapist in hearing testing programs is dependent upon the policies established by local school systems and departments of health. In general, the therapist should **not** be expected to become involved in extensive screening programs. However, therapists should definitely evaluate the hearing of each student on the case load and also become involved upon request in retesting selected cases.

There is a legal basis regulating hearing testing in Ohio. Section 3313.69 Ohio Revised Code provides that either boards of education or boards of health must evaluate students for visual and auditory defects. "The methods of making such tests and the testing devices to be used shall be such as are approved by the department of health." Boards of education may appoint a school physician. If they do not, Section 3313.73 Ohio Revised Code states that "the board of health shall conduct the health examination of all school children in the health district."

School Screening Programs

According to estimates by the Ohio Department of Health, between two and one-half and three percent of children have a hearing difficulty serious enough to require a referral to a physician for adequate diagnosis and treatment. Minimal hearing screening programs should include all children in the first, third, sixth and ninth grades, as well as new students and special referrals.

It is recommended that individual pure tone audiometry is the best screening method. The audiometer should be calibrated yearly to the International Standards Organization specifications. (See Appendix E)

In general, the following two-phase testing procedure is utilized:

I. A sweep test:

Generally, nurses or specificially trained volunteers conduct sweep tests, rather than school speech and hearing therapists. If a child fails to hear one or more tones in either ear at frequencies of 250, 500, 2,000, 4,000 and

8,000 Hz at a sound pressure level of 25 dB, (ISO, 1964), a threshold test should be given.

II. A threshold test:
Trained nurses and school speech and hearing therapists should conduct the threshold tests of hearing acuity of any child who fails a sweep test.

Once it has been established by the threshold tests that hearing difficulties are suspected, referral to a physician for diagnosis and treatment should be made as soon as possible. It is suggested that an individual conference with the parent prior to referral often relieves their anxiety and permits a mutual dissemination of valuable information. When a child is referred, most physicians appreciate receiving the results of the threshold testing and any significant observation by the teacher or therapist which might be pertinent to the case.

APPENDIX A

Suggested Record and Report Forms
Annual Report of Services

FORM I

.... PUBLIC SCHOOLS

SPEECH EVALUATION

Name.. **Birthdate**.................... **Age**...... **Sex**......

School.. **Grade**.......... **Room**..............

Parent or Guardian.............................. **Address**.................. **Telephone**........

Father's Occupation.............................. **Mother's Occupation**..........................

I. Articulation Test **Date:**.............. **Examiner**..

Type of Test: **Picture**.................. **Sentence**.................. **Other:**..................

Consonants:	I	M	F	Comments	Blends:	Comments		Comments
m					bl		sn	
b					fl		sp	
p					gl		st	
w					kl		sw	
h					pl		gz	
n					sl		ks	
t					spl		dw	
d					dl		kw	
k					tl		Vowels:	
g					zl		i (eat)	
n					br		I (sit)	
j					dr		e (ten)	
f					fr		ae (hat)	
v					gr		x (cup)	
to					kr		a (far)	
s					pr		p (top)	
l					shr		s (ball)	
8					skr		U (book)	
3					spr		u (moon)	
z					str		ju (new)	
s					tr		bv (nose)	
r					thr		au (cow)	
tz					sk		ei (cake)	
dz					skw		ai (tie)	
hw					sm		oi (boy)	

Note: Consonants listed in usual order of development according to West, Ansberry, Carr, **Rehabilitation of Speech** (third edition p. 60), Harper and Brothers, 1957.

Key: Record substitution errors with sounds substitute. Mark omission (—); Distortion (Dis.); Inconsistent (Inc.). Circle sounds when they are corrected.

II. Audiometric Evaluations:

Dates: ....

Results: Is hearing normal? Yes........; No........

III. Peripheral Speech Mechanism and Muscle Coordination: (check one on each line)

Lips: normal........; cleft........; mobility........

Teeth: normal......; maligned......; spaced......; missing......; false......; malformed........; supernumerary........

Jaw: normal........; open bite........; over bite........; under bite........; cross bite........; mobility........

Tongue: normal........; large........; small........; asymmetrical........; mobility........

Hard Palate: normal........; cleft........; repaired........;
contour: flat........; deep and narrow........

Soft Palate: normal........; cleft........; repaired........; asymmetrical........; mobility........

Nasal Cavities: normal........; septum: deviated........; nasal occlusion: right........; left........; nares constriction........

Breathing: normal........; uneven........; deep........; shallow........; rapid........

General Mobility of Oral Structures: ....
....

IV. Voice: (check one in each line)

Quality: normal........; hoarse........; harsh........; breathy........; nasal........; denasal........

Pitch: normal........; too high........; too low........; monotone........;
Pitch variability: adequate........: inadequate........

Intensity: normal........; too loud........; too soft........; uncontrolled........
Variability: adequate........; inadequate........

Rate: normal........; too rapid........; too slow........; uneven........; monotonous........

V. Skill of Expression:

General conversational speech: ....
....

Oral reading: ....
....

Expressive ability: ....

....

Receptive ability: ....

....

Speech adequacy: ....

....

VI. Classification of Speech Problem:

..................Articulatory	..................Cerebral Palsy
..................Language Disorders	..................Voice Disorder
..................Rhythm Disorders	..................Impaired Hearing
..................Cleft Palate and/or Lip	

Previous Speech Therapy:

Dates: ....

Results: ....

....

....

Speech Recordings Available? ....

....

VII. Related Data:

A. Defects of Vision: ....

....

B. School Achievement: Slow Learner....; Below average........
Average........; Above average........; Grades repeated ....

C. Name of Tests Given: (give dates and scores)

....

....

D. Gross Motor Coordination: ....

....

....

E. Fine Motor Coordination: ....

....

....

VIII. Remarks and Recommendations:

FORM II

OTORHINOLARYNGOLOGISTS REPORT

Name of child: .... Age.......... Parent: ....

Address: ....

Street City Zip Code

History of ear problem: ....

....

....

Ear, Nose and Throat Examination: ....

....

....

....

Diagnosis: ....

....

Prognosis: Stationary.............. Will Improve.............. Progressive..............

....

....

Was audiometric evaluation given? .... Result: ....

....

....

Medical Recommendation: ....

....

....

Should hearing aid evaluation be considered? ....

Please return to: .... M.D.

Title: .... Address: ....

Address: .... Date of Examination: ....

FORM III

REPORT OF LARYNGOSCOPY

Name of Child: .... Age: .... Parent: ....

Address: ....

Street City Zip Code

Date of Examination: .... Type: ....

General Health and Appearance: ....

....

....

Diagnosis: ....

....

Prognosis: ....

....

Medical Recommendation: ....

....

....

Should speech therapy be considered? ....

....

....

Do you recommend periodic checks? .... When? ....

....

Please return to: .... M.D.

Title: .... Address: ....

Address: .... Date of this report: ....

FORM IV

................................SCHOOL

SPEECH THERAPY LOG

Name: ....

Classification of speech problem: ....

Working on: ....

....

Date: ....

....

....

Date: ....

....

....

Date: ....

....

....

Date: ....

....

....

Date: ....

....

....

FORM V

.................................SCHOOL

FINAL CASE SUMMARY

Name: .... **School:** .... **Grade:** ....

Classification of Speech Problem: ....

Hearing: Normal...... **Recheck**...... **Referred**...... **Under Treatment**..........

Comments: ....

....

Voice: ....

....

Fluency: ....

....

Language Usage: ....

....

Number of Parent Conferences: Telephone.......... **Home**.......... **School**..........

Number of Conferences with: Teachers.........; **Principal**.........; **Nurse**.........;

Psychologist.........; **Other:** ....

....

Cooperation of Child: Cooperative........ **Indifferent**........ **Uncooperative**........

Cooperation of Parents: Cooperative........ **Indifferent**........ **Uncooperative**........

Attendance: Possible Days.......... **Days Present**.......... **Days Absent**..........

Summary of Treatment: Number of Individual Sessions..........................

Number of Group Sessions..........................

Results: ....

....

Recommendations: Dismiss...............; **Recheck**...............; **Retain**...............

....

....

....

Speech and Hearing Therapist

....

Date

FORM VI

..............................PUBLIC SCHOOLS

Space and Equipment Inventary
for
Speech and Hearing Therapy

Name of School.................................... Principal ....

Location of room to be used.................................... Size....................

Will room be shared? No........; Yes ....; If so, by Whom ....

Days room is available A.M. Mon. Tues. Wed. Thurs. Fri.

(Circle) P.M. Mon. Tues. Wed. Thurs. Fri.

Are there interruptions?.................................... Explain....................................

Is room quiet?.................................... Explain ....

Minimum equipment required under State Board of Education Standards:

5 Intermediate chairs (15-16 inch)

1 Intermediate height table to fit chairs

Therapist's Desk

Therapist's Chair

Bulletin Board............; Chalkboard............; Mirror.................... Size ....

Filing Cabinet............; Tape Recorder....................

	Satisfactory	Unsatisfactory	Needs Improvement as Follows:
Lighting			
Ventilation			
Heating			
Electrical Outlet			
Acoustics			

Comments: ....

....

....

....

Speech and Hearing Therapist

Approved for Service: By.................................... Date....................

(Superintendent or coordinator of Speech Therapy Program)

FORM VII

....SCHOOL

Results of Speech Survey

Principal..

School..

On.., a speech survey was made. The following is a statistical account of the findings:

Number of children seen in survey..............................

Number of children with speech problems Mild .... Moderate............ Severe............

Number enrolled in speech therapy..............................

Distribution of children enrolled in speech therapy classes according to grade and type of problem:

Problem	1st	2nd	3rd	4th	5th	6th	TOTAL
1. Articulation							
2. Stuttering							
3. Voice Disorders							
4. Language Disorders							
5. Cleft Palate							
6. Cerebral Palsy							
7. Hearing Impaired							

....

Speech and Hearing Therapist

Date of this report: ....

______________________SCHOOLS

Periodic Report to Superintendent
Speech and Hearing Services

Therapist:______________________ Date:______________

	SCHOOLS					
Screened for Speech						
Screened for Hearing						
Threshold Tests						
Need Therapy						
Speech Therapy Enrollment						
Speechreading Enrollment						
On Waiting List						
Corrected						
Dismissed						
Improved						
No Improvement						
Parent Conferences						
Telephone Calls to Parents						
Home Visits						
Classes Visited by Therapist						

Meetings or Conventions attended:

NAME	PLACE	DATE	PARTICIPANT

FORM VIII

....SCHOOL

Speech and Hearing Therapy
Semi-Annual Progress Report to the Superintendent

OBSERVATIONS OF CLINICAL WORK BY:

............Administrator

............Parents or Guardians

............Others

....
Speech and Hearing Therapist

....
Date

FORM IX

..............................SCHOOL

REQUEST FOR SPEECH AND HEARING EVALUATION

Name of Child: .... **Age:** .... **Grade:** ....

My interpretation of the speech and/or hearing problem: ....

....

....

....

....

....

Check other significant information:

............**Poor reader**

............**Avoids speaking in class**

............**Appears tense and nervous**

............**Inattentive in class discussions**

............**Discipline problem**

Teacher: ....

School: .... **Room**..............

Date: ....

STATE OF OHIO
DEPARTMENT OF EDUCATION
DIVISION OF SPECIAL EDUCATION

ANNUAL REPORT OF SPEECH THERAPIST

Speech and Hearing Therapist: ....

School District: .... County: .... Date: ....

I. Classification:

.... Defects of Articulation
.... Disorders of Language
.... Disorders of Rhythm
.... Cleft Palate
.... Cerebral Palsy
.... Disorders of Voice
.... Disorders due to Hearing Impairment
.... TOTAL

II. Report of Hearing Services:

.... Audiometric Screening Tests
.... Threshold Tests
.... Speechreading Instruction
.... Auditory Training
.... Children wearing hearing aids (enrolled in Speech Therapy)

III. Case Load Enrollment by Grades:

.... Elementary (K-3)
.... Elementary (4-6)
.... Junior High (7-8-9)
.... Senior High (10-11-12)
.... TOTAL (Same as I.)

IV. .... Number corrected or dismissed as having attained maximum improvement.

Approved: ....
Superintendent or Administrative Supervisor

INSTRUCTIONS FOR REPORTING
DUE ON OR BEFORE JUNE 21

Copies of the Annual Report of Speech and Hearing Therapy are to be made by each therapist in duplicate for each school district in which he works. One copy is to be retained by the superintendent and the other sent to: Educational Consultant, Speech and Hearing, 3201 Alberta Street, Columbus, Ohio 43204.

Speech centers are the buildings in which regular speech therapy classes are conducted. Children from other schools are to be counted in the class enrollment of the building in which they receive therapy.

Children scheduled from classes for slow learning children should be included in the same categories as others.

Count each child once in the category of his major difficulty. **Do not add or change classifications.** Data includes all children enrolled in speech therapy classes during the school year.

APPENDIX B

CODE OF ETHICS OF THE OHIO SPEECH AND HEARING ASSOCIATION

Loyalty and regard toward the association shall be manifested by:

A. Upholding the honor and dignity of the Association.

B. Promoting the welfare and interests of the Association and its members.

C. Establishing leadership and inspiring the regard of the general public in the field of speech and hearing therapy. Members shall safeguard as confidential and secret, conversations, case histories, diagnostic information and names of speech and hearing patients. Such privacy shall be protected both through adequate security of records and careful communication.

Members shall consider the following practices as unethical:

1. To guarantee to cure any disorder of speech.
2. To offer in advance to refund any part of a person's tuition of his disorder of speech is not arrested.
3. To make "rash promises" difficult of fulfillment in order to gain profit financially.
4. To use blatant or untruthful methods of self-advancement.
5. To advertise to correct disorders of speech entirely by correspondence.
6. To attack the work of other members of the Association or any Allied Association in such a manner as to injure their professional standing and reputation.
7. To attempt to deal exclusively with speech and hearing patients requiring medical treatment without the advice of or on the authority of a physician.
8. To continue treating a person after obvious recognition that he cannot improve beyond a certain point.
9. To charge exorbitant fees for treatment.
10. To use membership in this Association as part of an advertisement.

APPENDIX C

ROLE AND FUNCTION OF THE EDUCATIONAL CONSULTANT

The professional staff has a direct mandate from the Ohio Legislature and the State Board of Education to enforce minimum standards in local programs which are partially or fully reimbursed with state foundation money. Since approval for state foundation money is dependent upon maintenance of State Board of Education Standards, the role of the Educational Consultant is necessarily one of regulatory function. Program evaluation is a very small portion of the Educational Consultant's responsibilities. The two major responsibilities of the Educational Consultant are professional field service of which program evaluation is a part, and professional leadership. These responsibilities are not necessarily dichotomous. One cannot do professional field service without incorporating professional leadership. Field visits are made to school districts maintaining units in speech and hearing therapy in order to the Ohio Legislative mandate. They, also, are made to school districts requesting the consultative service of the Educational Consultant. Following every visit, a summary letter is sent to the local administrator and a copy to the superintendent.

A. Professional Leadership

This area of responsibility has many facets and it is not easily defined; however, the following outline describes some of the functions of the Educational Consultant in assisting local programs to develop and maintain optimal programs and services for speech and hearing impaired children.

1. Professional Literature and Materials
    - (a) Establish procedures by which local materials can be exchanged
    - (b) Periodically prepare a selected bibliography of significant materials
    - (c) Write or prepare materials that are needed but not available
2. Pre-Service Education Programs
    - (a) Assist in identifying unmet needs in university programs

- (b) Serve as an instructor on an emergency basis
- (c) Serve as a resource person for university students and instructors
- (d) Assist in the development of new professional curricula
- (e) Assist in the evaluation and improvement of existing professional curricula

3. In-Service Education Programs
   - (a) Provide professional field service
   - (b) Conduct and encourage area professional meetings
   - (c) Encourage and assist professional organizations
   - (d) Encourage and stimulate development of appropriate non-credit workshops and courses

4. Research Studies and Experimental Projects
   - (a) Identify research needs
   - (b) Initiate and conduct research
   - (c) Promote and encourage research studies and experimental projects
   - (d) Interpret and disseminate findings and conclusions

5. Professional Relations at the Local, State and National Level
   - (a) Maintain membership in professional organizations
   - (b) Attend meetings of professional organizations
   - (c) Contribute to journals of professional organizations

6. Appropriate and Desirable Criteria for Optimal Special Education
   - (a) Initiate procedures by which these criteria can be identified
   - (b) Encourage schools to use the criteria in self-evaluation
   - (c) Utilize criteria in professional field service

7. Extension of Present Programs in Special Education
   - (a) Identify unmet needs within present standards
   - (b) Assist local districts in establishing new programs or expanding established programs

8. Identification of Emerging Needs for New Programs in Special Education
   - (a) Identify unmet needs not now provided for within existing standards
   - (b) Encourage and stimulate the development of pilot studies and experimental programs
   - (c) Evaluate results of studies and submit recommendations for needed modifications in existing law and standards

The Division of Special Education has depended upon an Advisory Committee composed of representative people engaged in programs for speech and hearing impaired children for advice and counsel in the revision of standards for the approval of units, certification and general program needs. Meetings of this advisory committee are called by the Director when they are deemed advisable.

Ohio Department of Education
DIVISION OF SPECIAL EDUCATION
3201 Alberta Street, Columbus, Ohio, 43204

THE ROLE AND FUNCTION OF THE PROFESSIONAL STAFF IN THE DIVISION OF SPECIAL EDUCATION

Across Ohio new needs are emerging out of local programs for exceptional children. As these needs emerge and are identified, the role and function of the professional staff of the Division of Special Education are in need of evaluation and modification. To facilitate this evaluation, the staff has given consideration to the changing needs and the implications for the Division.

Several major issues can be identified. One issue is the relationship between general and special education. Special education is necessary because:

1. Significant physical, intellectual, social and emotional differences can be found in any group of children.
2. Children with significant deviations in physical, intellectual, social and emotional development are being recognized in increasing numbers throughout the State.
3. These exceptional children present instructional problems that cannot be met within the existing framework of the program of general education.

THEREFORE, SPECIAL EDUCATION PROGRAMS AND SERVICES EMERGE FROM THE PROGRAM OF GENERAL EDUCATION TO MEET THE INSTRUCTIONAL NEEDS OF EXCEPTIONAL CHILDREN.

Another major issue is the relationship between the regulatory and the leadership functions of the professional staff of the Division. The following factors are evident.

1. The professional staff has a direct mandate from the Ohio Legislature and the State Board of Education to enforce minimum standards in local programs which are partially or fully reimbursed with state monies.
2. Most local programs meet minimum state standards but many do not approach optimal goals in serving the needs of exceptional children.

3. The most common local problem in Ohio today appears to be the need for leadership and assistance in identifying, developing and maintaining optimal special education programs and services for exceptional children.

I. Professional Staff of the Ohio Department of Education, Division of Special Education

Director

- **Assistant Director**
  - Educational Consultant, Instructional Materials Services
  - Educational Consultant, Title VI
  - Educational consultant, Professional Development
- **Educational Administrator, Slow Learning**
  - Educational Consultant, Slow Learning
  - Educational Consultant, Slow Learning
  - Educational Consultant, Slow Learning
- **Educational Administrator, Pupil Services**
  - Educational Consultant, School Psychology
  - Educational Consultant, Program Development
  - Educational Consultant, Speech and Hearing
- **Educational Administrator, Physically Handicapped**
  - Educational Consultant, Audiologist
  - Educational Consultant, Hearing Impaired
  - Educational Consultant, Orthopedically and Visually Handicapped
  - Educational Consultant, Learning Disabilities and Behavior Disorders

II. Professional Field Services

The following procedures are a general guide in making visits and evaluating local programs and services in Special Education.

A. THE INITIAL CONTACT SHOULD BE MADE BY LETTER

1. This letter should be sent to the person in charge of the local special education program with a copy to the general administrator responsible for the program and in all cases to the superintendent of schools.
2. It should be mailed at least two weeks in advance of visit.

3. It should contain the following specifics:
    - (a) The date of the proposed visit, time of arrival and length of stay should be clearly indicated.
    - (b) The procedures and purposes of the visit should be clearly outlined.
    - (c) A request for an alternate date should be included if the date selected is not appropriate for the school personnel.

B. THE FIELD VISIT SHOULD INCLUDE THE FOLLOWING PROCEDURES

1. A personal contact with the person in charge of the local special education program should be made.
2. The purpose and procedures of the field visit should be outlined immediately upon arrival.
3. A structured set of criteria and procedures should be used to facilitate visitation.
4. Observations should be noted and questions should be raised about points in the program which are not clear.
5. Observations, suggestions and recommendations should be summarized in a conference near the end of the visitation.
6. The following priority of needs should be used in selecting programs for visits:
    - (a) Questionable programs
    - (b) New programs
    - (c) Experimental programs
    - (d) Established programs

C. THE FOLLOW-UP PROCEDURES SHOULD INCLUDE THE FOLLOWING REPORTS

1. A letter to the school district:
    - (a) This letter should be addressed to the person in charge of the local special education program with copies to the general administrator responsible for the program and in all cases to the superintendent of schools.
    - (b) The content of the letter should include a thank you note, a discussion of the program's strengths, a review of the discussion and suggestions, a list of standards not complied with and an outline of any further recommendations or activities.

2. A report to the Director:
    - (a) This report should include a copy of the letter sent to the school district.
    - (b) This report should identify problems in relation to organization, administration, personnel and instruction.
    - (c) This report should identify the most significant strengths and weaknesses of the program.
    - (d) This report should include any recommendations for future administrative action.

III. Professional Leadership

The following outline is a general definition of the role of the educational consultant in assisting local programs identify, develop and maintain optimal programs and services for exceptional children.

A. PROFESSIONAL LITERATURE AND MATERIALS
1. Establish procedures by which local materials can be exchanged.
2. Periodically prepare a selected bibliography of significant materials.
3. Write or prepare materials that are needed but not available.

B. PRE-SERVICE EDUCATION PROGRAMS
1. Identify unmet needs in university and staff program.
2. Serve as an instructor on an emergency basis.
3. Serve as a resource person for university students and instructors.
4. Assist in the development of new professional curricula.
5. Assist in the evaluation and improvement of existing professional curriculum.

C. IN-SERVICE EDUCATION PROGRAMS
1. Provide professional field services.
2. Conduct and encourage area professional meetings.
3. Encourage and assist professional organizations.
4. Encourage and stimulate development of appropriate non-credit workshops and courses.

D. RESEARCH STUDIES AND EXPERIMENTAL PROJECTS

1. Identify research needs.
2. Initiate and conduct research studies and experimental projects.
3. Promote and encourage research studies and experimental projects.
4. Interpret and disseminate findings and conclusions.

E. PROFESSIONAL RELATIONS AT THE LOCAL, STATE AND NATIONAL LEVEL

1. Maintain membership in professional organizations.
2. Attend meetings of professional organizations.
3. Contribute to journals of professional organizations.
4. Provide leadership for professional organizations.

F. APPROPRIATE AND DESIRABLE CRITERIA FOR OPTIMAL SPECIAL EDUCATION

1. Initiate procedures by which these criteria can be identified.
2. Encourage schools to use the criteria in self-evaluation.
3. Utilize criteria in professional field services.

G. EXTENSION OF PRESENT PROGRAMS IN SPECIAL EDUCATION

1. Identify unmet needs within present standards.
2. Assist local district in establishing new programs or expanding established program.

H. IDENTIFICATION OF EMERGING NEEDS FOR NEW PROGRAMS IN SPECIAL EDUCATION

1. Identify unmet needs not now provided for within existing standards.
2. Encourage and stimulate the development of pilot studies and experimental programs.
3. Evaluate results of studies and submit recommendations for needed modifications in existing law and standards.

APPENDIX D

Program Standards for Special Education Units for Deaf Children

Program Standards for Special Education Units for Hard of Hearing Children

Ohio
State Board of Education

EDb-215-01 PROGRAM STANDARDS FOR SPECIAL EDUCATIONAL UNITS FOR DEAF CHILDREN

(Adopted August, 1966)

(A) General

(1) A special education unit or fractional unit for deaf children may be approved only within these standards.

(2) A special education unit or fractional unit may be approved for an experimental or research unit designed to provide a new or different approach to educational techniques and/or methodology related to deaf children.

(3) A special education unit for supervision of a program including classes for deaf children and/or classes for hard of hearing children may be approved where there are ten or more units.

(4) The superintendent of the school district of attendance (or his designated representative) is responsible for the assignment of pupils to approved special education units.

(5) All children enrolled in an approved special education unit for deaf children shall meet the standards listed below.

(B) Eligibility

(1) Any educable child who meets the following requirements shall be eligible for placement in a special education unit for deaf children:

(a) Has an intelligence quotient of 50 or above based upon an individual psychological examination administered by a qualified psychologist, is capable of profiting substantially from instruction, and is of legal school age.

(b) Has a relatively flat audiometric contour and an average pure tone hearing threshold of 70 dB or greater for the frequencies 500, 1000 and 2000 Hz in the better ear (ISO-1964), or
Has an abruptly falling audiometric contour and an average pure tone hearing threshold of 70 dB or

greater in the better ear for the two better frequencies within the 500-2000 cps frequency range (ISO-1964), or
Functions as a deaf child and is approved for placement in a special education class by the Division of Special Education.

(2) A current audiological and otological examination shall be required for placement in approved special education units for deaf children. Periodic examination shall be required for continued placement in an approved program.

(3) Deaf children with intelligence quotients between 50-80 **should be placed in a special education program for slow learning deaf children.**

(C) Class Size and Age Range

(1) The enrollment of preschool age deaf children in a unit on a half-day basis shall be a minimum of 6 and a maximum of 8.

(2) In primary and intermediate units the minimum enrollment shall be 6 and a maximum of 8.

(3) The class size for junior high and senior high units shall be:

(a) A minimum of 6 and a maximum enrollment of 8 for self-contained classes.
(b) A minimum of 6 with the maximum enrollment not to exceed 12 when a minimum of 4 children are integrated into programs for hearing children.
(c) A minimum of 8 with the maximum enrollment not to exceed 15 when a minimum of 8 children are integrated into programs for hearing children.

(4) The chronological age range for a class of deaf children at any level of instruction shall not exceed 48 months.

(D) Housing, Equipment and Materials

(1) A special education unit for deaf children shall be housed in a classroom in a regular school building (or in a special public school) which meets the Standards adopted by the State Board of Education, with children of comparable chronological age.

(2) A special education unit for deaf children shall provide space adequate for the storage and handling of the special materials and equipment needed in the instructional program.

(3) A special education unit for deaf children shall provide the materials and equipment necessary for the instruction of these children.

   (a) Each classroom shall be equipped with suitable group auditory training equipment. Provision shall be made for maintenance and repair.

(E) Program

(1) Teachers of the deaf shall follow outlines and/or special courses of study in their daily program planning.

(2) A special education program for deaf children may be approved at the preschool, primary, intermediate, junior high school, and/or senior high school level.

(3) Special education programs for deaf children should provide continuing instructional programs and services from preschool through the secondary levels.

(4) Classes for deaf children may be organized as self-contained units in which the children receive full time instruction from the special teacher.

(5) Classes for deaf children may be organized so that provision can be made for some children to receive full time instruction from the special teacher while others receive some instruction from the special teacher and are integrated on the basis of the child's ability to succeed.

(6) There shall be written policies for the selection and placement of children in classes with hearing children on a full or part-time basis.

(7) There shall be evidence of periodic evaluation of the educational progress of all children placed in approved units for deaf children.

(F) Teacher Qualifications

(1) A teacher shall meet all the requirements for certification as established by the State Board of Education for this area of specialization.

Ohio
State Board of Education

EDb-215-02 PROGRAM STANDARDS FOR SPECIAL EDUCATION UNITS FOR HARD OF HEARING CHILDREN

(Adopted August, 1966)

(A) General

(1) A special education unit or fractional unit for hard of hearing children may be approved only within these standards.

(2) A special education unit or fractional unit may be approved for an experimental or research unit designed to provide a new or different approach to educational techniques and/or methodology related to hard of hearing children.

(3) A special education unit for the supervision of a program including classes for deaf children and/or classes for hard of hearing children may be approved where there are 10 or more units.

(4) The superintendent of the school district of attendance (or his designated representative) is responsible for the assignment of pupils to approved special education units.

(5) All children enrolled in an approved special education unit for hard of hearing children shall meet the standards listed below.

(B) Eligibility

(1) Any educable child who meets the following requirements shall be eligible for placement in a special education unit for hard of hearing children.

(a) Has an intelligence quotient of 50 or above based upon an individual psychological examination administered by a qualified psychologist, is capable of profiting substantially from instruction, and is of legal school age.

(b) Has a relatively flat audiometric contour and an average pure tone hearing threshold of 50 dB or greater for the frequencies 500, 1000 and 2000 Hz in the better ear (ISO-1964), or

Has an abruptly falling audiometric contour and an average pure tone hearing threshold of 50 dB or greater in the better ear for the two better frequencies within the 500-2000 Hz frequency range (ISO-1964), or

Functions as a hard of hearing child and is approved for placement in a special education class by the Division of Special Education.

(2) A current audiological and otological examination shall be required for placement in approved special education units for hard of hearing children. Periodic examination shall be required for continued placement in an approved program.

(3) Hard of hearing children with intelligence quotients between 50-80 **should be placed in special education program for slow learning hard of hearing children.**

(C) Class Size and Age Range

(1) In units where hard of hearing children receive all of their instruction with the special education teacher the minimum enrollment shall be 8 and the maximum 10.

(2) In units where the majority of the children receive instruction with a special education teacher and participate only in physical education, art and music classes, the minimum enrollment shall be 8 and the maximum 12.

(3) In units where hard of hearing children are integrated but receive instruction with a special education teacher in lipreading drill and practice, auditory training, speech therapy and tutoring in academic subjects, the minimum enrollment shall be 8 and the maximum 15.

(4) The chronological age range for a class of hard of hearing children at any level of instruction shall not exceed 48 months.

(D) Housing, Equipment and Materials

(1) A special education unit for hard of hearing children shall be housed in a classroom in a regular school building (or in a special public school) which meets the Standards adopted by the State Board of Education, with children of comparable chronological age.

(2) A special education unit for hard of hearing children shall provide space adequate for the storage and handling of the special materials and equipment needed in the instructional program.

(3) A special education unit for hard of hearing children shall provide the materials and equipment necessary for the instruction of these children.

  (a) Each classroom shall be equipped with suitable group auditory training equipment. Provision shall be made for maintenance and repair.

(E) Program

(1) Teachers of hard of hearing children shall follow outlines and/or special courses of study in their daily program planning.

(2) Classes for hard of hearing children may be organized as self-contained units in which the children receive full time instruction from the special teacher.

(3) Classes for hard of hearing children may be organized so that provision can be made for some children to receive full time instruction from the special teacher, while others receive some instruction from the special teacher and are integrated on an individual basis in proportion to the child's ability to succeed.

(4) Special education units for hard of hearing children shall be approved at the secondary level only on an experimental or research basis as outlined in (A) (2). Proposals for these must be submitted prior to application for approval.

(5) Special consideration for placement in secondary school programs should be given those hard of hearing children who received instruction in special education classes through the elementary school. Other alternatives which may be considered in addition to that outlined above are:

  (a) Assignment to a regular class on a full-time basis if no additional instruction with special teacher is needed.

  (b) Assignment to an approved class for slow learning children if they have sufficient mastery of special skills (lipreading, auditory training, speech and language), do not require additional instruction with hard of hearing and are capable of profiting from this instruction.

(c) Assignment to an approved special education class for deaf children if their needs in the language arts subjects are comparable to those of deaf children at this level.

(6) There shall be written policies for the selection and placement of children in classes for hearing children on a full or part-time basis.

(7) There shall be evidence of periodic evaluation of the educational progress of all children placed in approved units for hard of hearing children.

(F) Teacher Qualifications

(1) A teacher shall meet all the requirements for certification as established by the State Board of Education for this area of specialization.

APPENDIX E

International Standards Organization Recommendations

STATE OF OHIO
DEPARTMENT OF EDUCATION
COLUMBUS

The international Standards Organization has announced its recommendation for an international standard reference level for pure tone audiometers. The Committee on Conservation of Hearing of the American Academy of Ophthalmology and Otolarynology has endorsed the new Audiometric Zero. The Committee and its Subcommittees on Audiometers favor the early and universal use of the new ISO-1964 scale. It has already been announced by several professional societies that the ISO-1964 scale be required henceforth for any audiograms that are to be published in their journals.

For many years confusion has existed among otologists and audiologists due to the use of different standards by those making audiometric measurements in the United States and by those in most European countries. The new scale represents an international agreement reached after years of measurement, calculation and discussion. The adoption of the new standards will have two primary objectives: (1) to provide a better representation of the hearing threshold curve of young adults and (2) to terminate the confusion and ambiguity presently encountered when comparing test results obtained in various parts of the world. Today, scientific publications in this discipline must be prepared for an international audience.

The Ohio Department of Education, Division of Special Education encourages the use of the new ISO-1964 audiometric standards and suggests that personnel responsible for hearing testing programs arrange for the recalibration of all ASA-1951 audimeters to the new standards during 1965. The changes resulting from the adoption of the new standards relative to conservation of hearing programs are outlined in a release prepared by the Ohio Department of Health, Hearing and Conservation Unit, Division of Maternal and Child Health.

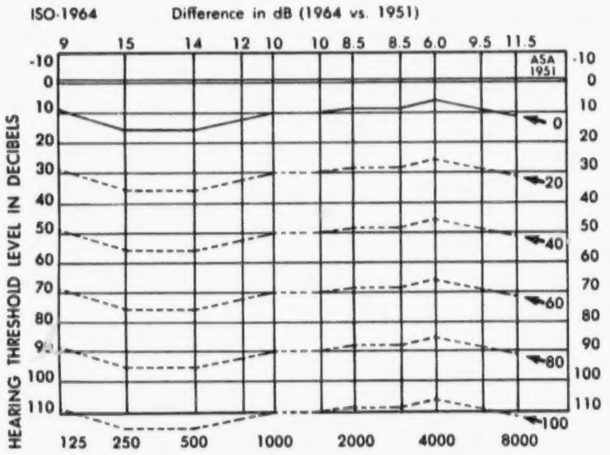
The importance of indicating on *each* new audiogram whether it is plotted according to the 1951 ASA reference thresholds or according to the 1964 ISO reference thresholds cannot be over emphasized, especially during this transition period. In addition, the use of appropriate new audiogram forms with the conversion factors (difference in db) stated thereon *plus* the printed statement relative to the use of these values in changing from one scale to another is recommended.

SAMPLE

Name____________________________

Date______________

Birth Date__________



Ave. Pure Tone Hearing Loss (500 - 2000 cps)

	Left	**Right**
	db	**db**

Thresholds

Left	**Right**	**Field**
db	**db**	**db**
db	**db**	**db**

This audiogram is plotted on the basis of:

☐ 1964 ISO reference thresholds
☐ 1951 ASA reference thresholds

Readings obtained on an audiometer calibrated to the 1951 ASA thresholds may be converted to, and plotted as, "Hearing Threshold Levels" based on the 1964 ISQ reference thresholds by adding the appropriate "Difference in dB" at each frequency. To convert readings based on the 1964 ISQ reference thresholds to readings based on the 1951 ASA reference thresholds, subtract the "Difference in dB".

The above sample audiometric form is suggested for use by those who have converted to the new ISO threshold levels.

Most of the proposed new audiogram blanks for use with audiometers calibrated to the ISO-1964 scale represent the ISO scale as the primary grid with the ASA-1951 grid appearing in the background, usually as a series of broken lines and threshold level markings as in the above example. This makes the relationship between the two scales as clear as possible.

For those who have been unable to have audiometers recalibrated to the ISO-1964 standards, it has been proposed that an audiogram similar to the above sample be used except that the primary grid would represent the ASA-1951 scale while the ISO grid would appear in the background. In either case the exact difference in db between the two scales for each frequency should appear either at the top or the bottom horizontal line of the pure tone audiogram form. This provision enables one to make rapid conversions from one db value to another.

The difference between the two scales is approximately 10 db. Specifically, you will note that the differences range from 6 to 15 db, depending upon the particular frequency under consideration. The relationship between the scales is such that the db difference values are added when transposing from the ASA scale to the ISO scale, and subtracted when converting from ISO to ASA values. Following the above conversion principle, the db difference value of 11 db should be used when translating *average* pure tone hearing levels for the "speech range" (500, 1000 and 2000 cps) from one scale to another. Therefore, with reference to the standards adopted by the State Board of Education for Special Education Units, under Units for Deaf Children (2.21) the 60 decibel figure should represent a 71 db hearing threshold level for those using the ISO-1964 scale. Likewise, under Units for Hard of Hearing Children (3.21) the 40 decibel figure should be replaced by a 51 db hearing threshold level for those using ISO pure tone audiometric data.

The following references are listed as reading suggestions for further discussion and clarification of the above subject:

1. Davis, H., and Kranz, F.: International Standard Reference Zero for Pure-Tone Audiometers and Its Relation to Evaluation of Impairment of Hearing, Jr. Speech Hearing Res. 7:7-16, 1964.
2. Committee on Conservation of Hearing: Audiometric Reference Zero Levels: Old and New, J. Am. Speech and Hearing Assoc. 7:59 & 60, 1965.
3. Davis, H.: The ISO Zero-Reference Level for Audiometers, Arch. Otolarying. 81:145-149, 1965.
4. Subcommittee on Noise of the Committee on Conservation of Hearing, and Research Center Subcommittee on Noise, Aram Glorig, Director: Guide for Conservation of Hearing in Noise 32-38, Revised 1964.

cc: Speech therapists
Supervisors, Deaf and Hard of Hearing